

Member Name _____ MA# _____ POC Time Frame _____

ADDITIONAL SERVICES AND SERVICE COORDINATION			
ADDITIONAL SERVICE	SERVICE SYSTEM/ PROVIDER	RESPONSIBLE PERSON	COMMENTS
Case Management Services (Authorized by use of INOF) <input type="checkbox"/> Administrative-BSU <input type="checkbox"/> ICM <input type="checkbox"/> RC <input type="checkbox"/> ISC (MR)			
Outpatient Therapy (Authorized by use of INOF)			
Partial Hospitalization			
Medication Management (Authorized by use of INOF)			
Drug and Alcohol Services			
Mental Retardation Services <input type="checkbox"/> FSS <input type="checkbox"/> Title IXX			
CYF			
Juvenile Justice			
School Name <input type="checkbox"/> Reg Ed <input type="checkbox"/> IEP <input type="checkbox"/> APS			
Primary Care Physician			
Community Resources			
Mobile Crisis Services			
Comments/Clarifications:			

Instructions for Completing the Plan of Care Summary

Please complete the top right corner box. Indicate whether this is an Initial POC, Continued Stay POC or an Amendment to a current POC.

Member Information: Complete all fields. It is mandatory that all 5 diagnostic axes be complete. Indicate “No Diagnosis” rather than leaving an axis blank. Include DSM-IV codes.

Contact Information: Identify the primary provider contact for this plan by name and phone. For Date of Last PCP Contact, indicate when you as the BHRSCA provider last contacted the member’s PCP for coordination and communication. Indicate the most recent date in which EVS was checked to confirm the member’s eligibility with CCBH. POC time period refers to the dates of service for this request. A typical plan will be authorized for a 4 month period. The end date typically is 1 day less than the start date, 4 months later. On continuing stay reviews, please check dates to ensure continuity of the authorization.

BHRS Service Plan: Authorizations for this BHRSCA Service Plan will be entered directly from the data recorded in this section of the Plan of Care. In order to increase consistency, Community Care is defining 1 month of service as 4.5 weeks. Therefore, for a typical 4-month plan, Community Care will authorize 18 weeks of service. MR Providers, please add the necessary modifier to the procedure code for services to children/adolescents with MR diagnoses. Authorization for Initial Life Domain Psych Evals must be requested by use of the attached Extended Assessment and Life Domain Authorization Request form. Life Domain Re-evals may be authorized by inclusion on the POC only when the BHRSCA provider and the Prescriber are the same billing entity. In this case, please be certain to correctly identify the individual or facility to which the authorization is to be given in the “Responsible Person” block. Then circle Y to the question “To be authorized from this Plan of Care?”. Authorizations for Psych Re-evals completed by a prescriber billing through an entity other than the BHRSCA provider are to be requested by faxing the Extended Assessment and Life Domain Authorization Request form to CCBH. Neuropsych Testing may be authorized by a POC when the BHRSCA Care Manager has been consulted and is in agreement that this service is medically necessary. If agreement has not been reached, the provider may submit a request for neuropsych testing to be reviewed by a CCBH Physician Advisor.

The table will assist the provider in the calculation of total units to be authorized by requesting the maximum hours per week, X the total number of weeks, X the units per hour. CCBH will now authorize total units for each service for the entire duration of the plan of care. The exception to this process is cases in which a titration of services is clearly delineated on the POC.

Additional Services and Service Coordination: Summarize all additional services being received by the member. Also include information about the other child-serving systems the member is involved with.