**MHCP (MA) Authorization -documentation needed**

Revised 1/18/18

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| **Notes per Jenny for MA Authorization~ (1/18/18)**  The (CAGE and WHODAS) are the instruments currently "preferred" by MN Medicaid (Straight MA). Our PHQ already covers the DHS assessment requirements (including the alcohol assessment) and the SDQ is already the "required" instrument for minors for Medicaid.  I would recommend completing these 2 instruments (WHODAS and CAGE) for any ADULT client with Straight MA (or Pmap client who switches to Str MA) who you are at risk for needing to request the authorization for Straight MA sessions beyond the first 26 each year.  If your client has a Pmap and does not switch to Straight MA, I wouldn't worry too much about it (as our PHQ and SDQ meet the requirements and that is why we use them). Straight MA changes their mind periodically as to what they specifically want to see in order to approve an auth. If you miss doing these at the intake, then do them as soon as you are able. Make an addendum note to the DA report that you completed it and on what date and the results.  *We are NOT going to start sending these out to new clients scheduling.*They already have enough to complete prior to coming in. And, I do not want to bother keeping up with the latest hoop that Str MA wants us to jump thru and switching up these instruments all the time. We complete relatively few MA Auths each year, so this would really not be worth anyone's time.  I am attaching the 12 question WHODAS, which is also accepted (and I would recommend using that one to keep things simple) - just take a few moments in session to complete it during the intake (or ASAP if you cannot complete it at that time for some reason).  Here is the newest update specific to Medicaid (Str MA) dated 12/19/17 and the Standard Diagnostic Assessments (which is what we do):  [**https://www.dhs.mn.gov/main/idcplg?IdcService=GET\_DYNAMIC\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\_163297**](https://www.dhs.mn.gov/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163297)  Here is the simple scoring info for the 12 item WHODAS:  There are two basic options for computing the summary scores for the WHODAS 2.0 short and full versions  Simple: the scores assigned to each of the items – “none” (1), “mild” (2) “moderate” (3), “severe” (4) and “extreme” (5) – are summed. This method is referred to as simple scoring because the scores from each of the items are simply added up without recoding or collapsing of response categories; thus, there is no weighting of individual items. This approach is practical to use as a hand-scoring approach, and may be the method of choice in busy clinical settings or in paper–pencil interview situations. As a result, the simple sum of the scores of the items across all domains constitutes a statistic that is sufficient to describe the degree of functional limitations.  **Link for more info:**[**http://www.who.int/classifications/icf/whodasii/en/index4.html**](http://www.who.int/classifications/icf/whodasii/en/index4.html)  **Authorization** |

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**Authorization needed when exceeded:**

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| • 26 hours psychotherapy (with patient and/or family member)(including biofeedback) per calendar year, cumulative |

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| ***\*\*Submit the following as part of the authorization process for continuation of services:*** |

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| • Copy of the most current diagnostic assessment (must be labelled as 1 of 4 different types, see *MHCP DA Requirements* handout) |

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| • Clinical summary (including justification for each diagnosis) |

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| • Individual treatment plan that includes: | |
| • Measurable and observable goals |

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| • Start and end dates |

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| • No status statements |

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| • Progress notes that include: | |
| • Type of service |

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| • Date of service |

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| • Session start and stop times |

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| • Scope of service (nature of interventions or contacts, treatment modalities, phone contacts, etc.) |

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| • Recipient’s progress (or lack thereof) to overall treatment plan goals and objectives |

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| • Recipient’s response or reaction to treatment intervention(s) |

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| • Formal or informal assessment of the recipient’s mental health status |

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| • Name and title of person who gave the service |

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| • Date documentation was made in the client record --Should anyone who has a client who thinks they may eventually need an auth from straight MA should start adding a line in their progress notes addressing when they wrote their progress note. According to their expectations, this is the only requirement that our notes don't automatically comply with. Can be as simple as "Note written: (insert date)". |

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| • Other elements that may apply, including: |
| • Current risk factors the recipient may be experiencing | |

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| • Emergency interventions |

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| • Consultations with or referrals to other professionals |

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| • Summary of effectiveness of treatment, prognosis, discharge planning, etc. |

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| • Test results and medications |

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| • Symptoms |

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| When requesting authorization for services that are to be performed with interactive complexity, include the Interactive Complexity add-on code on the authorization request. |