**Brain Injury Services Case Management (BIS TCM)**

**Service Authorization Review Form – Initial Requests**

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| **Fax Form to Respective Health Plan Using Contact Information Below**  **PLEASE TYPE INFORMATION IN THIS FORM – MUST BE COMPLETED BY APPROPRIATELY CREDENTIALED CASE MANAGER AS REQUIRED BY DMAS**  **Supporting clinical information including discharge summaries may be attached to this form.** | | |
| **MEMBER INFORMATION** | | |
| Member Name: | | DOB: |
| Member ID: | If retroactively enrolled, provide enrollment date: | |
| **PROVIDER INFORMATION** | | |
| Case Mgt Provider Name: | | Case Mgt Provider NPI: |
| Street Address: | | Case Manager Fax #: |
| City | State | Zip: | |  |
| Case Mgt Contact Person Name (first and last): | | Physician Name/NPI: |
| Case Mgt Contact Person Phone: | | Physician Contact Person Phone: |
| **Medical documentation supporting diagnosis of TBI included?**  **Yes**       **NO**  ICD-10 Diagnosis Code confirming TBI=  **MPAI-4 Completed? Yes**       **NO**  **(The MPAI-4 must be completed to receive authorization for TCM)**  **S0281- 1 unit per Month**       check box    **S0281 Case Management Services Start Date:**  **S0281 Case Management Services End Date:**  **NOTE: Date range requested for TCM, not to exceed 6 months.** | | Is the Member receiving Case Management now?  Yes       No  If yes, which Medicaid Service? ID       DD       ARTS     MH       TFC  Completed MPAI-4 scoring sheet is attached?  Yes       NO  Preliminary plan of care (POC) for new SA request or updated POC attached for ongoing SA request?  Yes       NO |

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| **MPAI-4 Scoring Criteria for Identifying Eligibility for BIS TCM**  **The MPAI-4 (the Mayo Portland Adaptability Inventory) is used to identify severity level**  **of the member’s functional deficits as a result of their TBI** | | |
| Enter MPAI-4 T-Score here: \_\_\_\_\_\_\_\_\_\_\_     .  If the MPAI-4 T-score is 60 or greater, then the member meets the functional eligibility criterion of having severe functional deficits as a result of their TBI.  If the MPAI-4 T-score is less than 60, but equal to or greater than 50 (MPAI-4 T-score is in the range of 50 to 59); then complete the table below of additional item-specific scoring criteria to identify if the member meets the functional eligibility criterion of having severe functional deficits due to the TBI:  The RESPONSE TO AT LEAST ONE ITEM-SPECIFIC SCORING CRITERION, among all of the below item-specific scoring criteria UNDER EITHER ONE OF THE FOUR PARTS: PART A: Ability Index, PART B: Adjustment Index, PART C: Participation Index, and PART D: Pre-existing and Associated Conditions; NEEDS TO BE A “YES” to meet the eligibility criterion of having severe functional deficits as a result of the TBI. | | |
| **If criterion met:**  **Check the box in the “YES” column.**  **If criterion not met:**  **Check the box in the “NO” column** | | **Item-Specific Scoring Criterion** |
| **ABILITY INDEX** |
| **YES** | **NO** | **Physical Abilities** |
|  |  | A score of **4** on Item 1: Mobility  ***and***  A score of **4** on Item 2: Use of Hands |
|  |  | A score of **4** on Item 3: Vision  ***and***  A score of **4** on Item 4: Audition |
| **YES** | **NO** | **Cognition** |
|  |  | A score of **4** on Item 8: Attention/Concentration |
|  |  | A score of **4** on Item 9: Memory  ***and***  A score of **4** on Item 10: Fund of Information |
|  |  | A score of **4** on Item 9: Memory  ***and***  A score of **4** on Item 11: Novel Problem-solving |
| **YES** | **NO** | **ADJUSTMENT INDEX** |
|  |  | A score of **4** on Item 14. Depression |
|  |  | A score of **4** on Item 15. Irritability, anger, aggression |
|  |  | A score of **4** on Item 20. Impaired self-awareness |
| **YES** | **NO** | **PARTICIPATION INDEX** |
|  |  | A score of **4** on Item 25: Self-care |
| **YES** | **NO** | **PRE-EXISTING and ASSOCIATED CONDITIONS** |
|  |  | POST-INJURY SCORE: A score of **4** on Item 32: Psychotic symptoms |

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| **SIGNATURE OF STAFF COMPLETING THE FORM** | |
| **Name (print):** | |
| **Signature/Credential:** | **Date:** |

**PLEASE SEND THIS FORM TO THE DESIGNATED HEALTHCARE PLAN USING THE CONTACT INFORMATION BELOW FOLLOWING THE TIME FRAME REQUIREMENTS IN THE BIS TCM PROVIDER MANUAL.**