**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.**