## MULTNOMAH MENTAL HEALTH

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR) FORM**

## FAX (503) 988-3137 or Secure Email [URTEAM@MULTCO.US](mailto:URTEAM@MULTCO.US)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name:                   DOB:       Gender:

Last First Middle initial *(M/D/YYYY)*

Member Address:

Street Address

            Phone:

City, State Zip Code

**ELIGIBILITY INSURANCE INFORMATION**

Health Share of Oregon Multnomah Mental Health Medicaid/OHP #:

Medicare Primary Medicaid Co-Pay Only

AMHI Funded

Third Party Insurance *(if any):* Carrier       group/policy #      and effective date

**PERSON SUBMITTING REQUEST**

Requester Name/Relationship to member:

Phone:       Fax:       Email:

**PSYCHOLOGIST/PROVIDER REQUESTED**

Provider/Agency:       Phone:       Fax:

Address:

Is provider in-network? Yes Contracted MMH provider  No, out-of-network

Contact person:       Phone:       Fax:

Email:

Service requested:

Requested start date:       Projected end date:

Tests proposed to address referral question:

|  |  |  |
| --- | --- | --- |
| Name of Test | Purpose | Time Needed |
| ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­ | ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­ | ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­       ­­­­­­­­­ |

Total Hours of testing requested (include administration, scoring, and write-up)

Total Amount Requested $       *\**Per MMH Policies: $110/hour Max benefit of $880

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR) CLINICAL INFORMATION & CLINICAL JUSTIFICATION for PSYCHOLOGICAL EVALUATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Submit additional clinical documentation with all treatment authorizations requests. Please include recent Mental Health Assessment (within last 60 days) and previous psychological evaluation(s) if available. Answer all questions below and provide enough clinical information to justify psychological evaluation being requested.**

\*Is the primary or sole purpose of testing to assess a medical condition (i.e. Fetal Alcohol Syndrome, Pervasive Developmental Disorder, Autism, ADHD, TBI, Cognitive Deficits)?  Yes  No.

If yes, please defer to member’s medical plan.

\*Is the Primary purpose of testing to determine eligibility (i.e. Disability services, IEP)?  Yes  No.

If yes, please refer to appropriate eligibility system as this is not a covered service by MMH.

Referral question (s):

|  |
| --- |
|  |

Mental Health Diagnoses and Code #(s):

R/O Diagnoses:

Presenting Problem and Reason for Referral:

|  |
| --- |
|  |

Pertinent Psychiatric/Mental Health History:

|  |
| --- |
|  |

Previous Psychological Testing (Include dates and results): [Please request records of previous testing prior to submitting request to determine if referral question can be answered by previous testing]

|  |
| --- |
|  |

Reasons referral question(s) cannot be answered by diagnostic interview, review of records, past psychological testing, behavioral observation, or collateral information:

|  |
| --- |
|  |

Treatment implications: Please address the specific ways testing results will inform treatment, how results will have a meaningful impact on treatment planning, and how testing will significantly benefit member’s mental health condition and functioning:

|  |
| --- |
|  |

**INSTRUCTIONS FOR EXCEPTIONAL NEEDS**

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)**

Please be aware that insurance eligibility may change from month to month. Providers are to verify client enrollment prior to each session and before submitting a PTAR form.

**Pre-Authorization Procedure:**

* Requests to authorize psychological evaluation must be made in writing. Fax or secure email completed PTAR with clinical documentation to Utilization Review at Health Share of Oregon Multnomah Mental Health (MMH).
* A Psychological Testing Authorization Request (PTAR) form is available upon request from MMH.
* PTAR must be complete. Requests will not be reviewed until all information needed is provided to MMH and considered a completed request. Information that should be provided is outlined below.
* Determination will be made within 14 days of **completed** request. Provider will receive notification of authorization approval, denial, or the need for additional clinical material within 14 days of receipt of a complete PTAR.
* **Pre-Authorization required.** All testing and psychological evaluations authorized prior to evaluation in order to receive payment for services. At any point in the course of testing, further funds must be requested in advance and pre-authorized. Requests for additional testing and time are reviewed based on clinical discretion of MMH utilization review specialist and may be requested based on medical necessity.

Follow instructions provided with PTAR form and include the following (These questions are included in the above form):

* Member identification information including Medicaid/OHP #, or other 3rd party insurance policy #
* Provider information
* Recent Behavioral Health Assessment (within last 60 days) and updated treatment plan and needs.
* Dates of anticipated testing; total hours and dollar amount being requested; specific tests and purpose.
* Current OHP covered mental health condition/diagnoses, including working diagnosis and rule out diagnoses.
* Specific referral question or questions. Include why these cannot be answered by means of a diagnostic interview/assessment, review of records, collateral information, previous testing, and/or behavioral observations.
* Presenting problem and history of present illness.
* Previous testing and results. Justification of why additional testing is necessary.
* Treatment implications. Please address the specific ways that the testing results will inform the member’s treatment, how results will have a meaningful impact upon treatment planning, and how testing will significantly benefit member’s mental health condition and functioning.

AMHI: For information regarding authorizations for AMHI funded clients, please call Member Services (503) 988-5887 and request to speak with the AMHI supervisor.

**Reimbursement and Claims Submission**

Health Share of Oregon Multnomah Mental Health (HSOMMH)/Multnomah County AMHI will pay contracted providers according to the contract terms agreed upon between provider and HSOMMH/Multnomah County AMHI for services provided to HSOMMH members who are enrolled in HSOMMH on the date of service. When HSOMMH is the primary payor, provider will submit detailed claims using the CMS 1500 claim form to PH Tech within 90 days from the date health care services were delivered. When the member is covered by other insurance and HSOMMH is not the primary payor, provider will submit detailed claims using the CMS 1500 claim form and the primary payor EOB to PH Tech within 12 months from the date health care services were delivered. Claims later than these time frames may be denied. Provider shall submit claims to:

PH Tech

PO Box 5490

Salem, OR 97304

Attn: Health Share of Oregon Multnomah Mental Health Claims Processing

Provider must use due diligence in collecting third party resources to offset the cost of the member's mental health treatment. Provider shall make all reasonable efforts to collect from payors (specifically government programs, commercial insurance, or other third party payors, private or otherwise), for all eligible and contracted costs associated with the member's care. For members with dual eligibility, provider must bill and follow the rules of primary insurance provider (including any authorization requirements) prior to submitting claims for Health Share of Oregon Multnomah Mental Health payment.