Treatment Foster Care-Case Management
Prior Authorization Request Fax Form

KePRO/DMAS now require any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp

☐ **Initial Review** ☐ **Continued Stay Review** ☐ **Retro Authorization** ☐ **Change Request**

FAX: 1-877-OKBYFAX (877-652-9329) / Phone: 1-888-827-2884

Please utilize the instructions when completing this form

1) Locality Code:	**2) KePRO Case ID Number:** **(Continued Stay Review only)**	**3) Start Date requested: / /** **Admission Date: / /** **Requesting retroactive authorization:** ☐ **Yes** ☐ **No**	**4) Expected Discharge Date: / /** **Discharge plan:**

5) Enrollee Last Name:	**6) Enrollee First Name:**	**7) Enrollee Medicaid ID # :**

8) DOB (mm/dd/yyyy)**:** / /	**9) Gender:** ☐ Male ☐ Female	**10) Provider Name:**	**11a) Provider Address:** **11b) 9 digit Zip Code *(Mandatory)***

12) NPI/API Provider #:	**13) Contact Person:**	**14) Provider Phone:**	**15) Provider Fax:**

16) DSM IV:

Axis I ______________________________
Axis II ______________________________
Axis III ______________________________
Axis IV ______________________________
Axis V (GAF) Current: Highest level in past year:

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Enrollee Last Name:	**Enrollee First Name:**	**Enrollee Medicaid ID # :**

17) Case Management

A) FAPT Assessment contains all required elements. Yes ☐ No ☐ (Initial Review Only)
I**.** Date of FAPT Assessment:

B) Date of Comprehensive Treatment and Service Plan: (First Continued Stay Review Only)

C) The locality and clinicians working with this child have determined continued TFC-CM is required to meet the child's needs. Yes ☐ No ☐

D) Two face-to-face contacts between the case manager and the child have occurred each month to ensure the child is receiving safe and effective services. (Continued Stay Reviews Only) Yes ☐ No ☐

18) Current Behaviors: For the initial review, provide a narrative of the behaviors exhibited by the client over the past 30 days that warrant the requested level of care (please identify frequency, intensity and duration of each behavior).This information should reflect the scoring on the CANS summary sheet. For continued stay this information should come from the most current 90 day progress report.

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Enrollee Last Name:	**Enrollee First Name:**	**Enrollee Medicaid ID # :**

19) Please provide complete scores/dates for CANS:

CANS: **Date: / /**		**2=Causing problems, consistent with diagnosable <u>disorder.</u>**		**3=Causing severe / dangerous <u>problems</u>.**		**2 = <u>Recent, Act.</u>**	**3 = Acute, Act <u>Immediately.</u>**
<u>Child Behavioral/ Emotional Needs</u>					**<u>Child Risk Behaviors</u>**		
Psychosis					Suicide Risk		
Impulse / Hyper					Self-Mutilation		
Depression					Other Self-Harm		
Anxiety					Danger to Others		
Oppositional					Sexual Aggression		
Conduct					Runaway		
					Delinquent Behavior		
Adjustment to Trauma					Fire Setting		
Anger Control					Social Behavior		
Substance Use					Sexually Reactive Behavior		
Eating Disturbance					Bullying		

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TREATMENT FOSTER CARE--CASE MANAGEMENT SERVICES ELECTRONIC FAX FORM INSTRUCTIONS
www.dmas.kepro.org
www.dmas.virginia.gov

This FAX submission form is required for TFC-CASE MANAGEMENT prior authorization review.

Please be certain that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via FAX for additional information.

If KePRO determines that your request meets appropriate review guidelines the request will be “tentatively approved” and transmitted to First Health Services (FHS) for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iEXCHANGE (http://dmas.kepro.org) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS’ Fiscal Agent prior to 5:30 PM of that day.

Request type:

- Place a √ or **X** in the appropriate box.
- **Initial Review:** Use for all new requests, unless the recipient has been in care for more than 30 days, then check continues stay review.
- **Continued Stay Review**: Use for concurrent reviews and for new clients who have been in care for over 30 days. All (extension) submissions should be under Continued Stay Review.
- **Retro Authorizations**: Use when Medicaid eligibility was determined after the admission date. Please include date you were notified of eligibility.
- **Change Request Review**: A change to a previously approved request may be submitted if necessary for an early discharge from services. Please include the existing PA # on the request form and reason for change (discharged early, relocated etc.)

1. **Locality Code**
    - Enter the 3 digit locality (FIPS) code in the text box. The locality code will reflect the locality that has fiscal responsibility for the Medicaid recipient and should be provided by the referral source. (Please see the attached list of locality codes)
2. **KePRO Case ID #:**
    - For Continued Stay requests or change requests only
    - Case ID # is located on all KePRO fax notifications

3. **Start Date requested:**
    - The date you want the requested service to begin.
    - The Original admission date
    - Place a √ or **X** in the appropriate box if this is a retroactive request.
4. **Expected Discharge (D/C) Date and Discharge placement:**
    - Enter the expected discharge date on the line provided.

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- Enter the expected discharge placement on the line provided (i.e. permanent foster care, return home, adoption, etc.)

5. Enrollee Last Name:

- Enter the enrollee's last name exactly as it appears on the Medicaid card.

6. Enrollee First Name:

- Enter the enrollee's first name exactly as it appears on the Medicaid card.

7. Enrollee Medicaid ID Number:

- It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.

8. Date of Birth:

- Enter the enrollee's date of birth in the MM / DD / YYYY format (for example, 02/25/2008)

9. Gender:

- Please place a √ or **X** to indicate the gender of the enrollee.

10. Provider Name:

- Enter the requesting/service provider name

11. Provider Address:

- a. Enter the requesting/service provider's business address.
- b**. 9 digit Zip Code (Mandatory):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.

12. Provider NPI/API Number:

- Enter the Provider NPI/API number for the provider requesting the service.

13. Provider Contact Person:

- Enter the primary contact for the requesting/service provider.

14. Provider Phone Number:

- Enter the phone number of the requesting/service provider.

15. Provider Fax Number:

- Enter the fax number of the requesting/service provider.

16. DSM-IV Diagnoses:

- Enter the complete DSM-IV diagnosis **(Must include all 5 Axes)**

17. Case Management :

a. Place an X in the box that corresponds to whether or not the FAPT Assessment contains all of the required elements and provide the date assessment completed --See requirements in the DMAS Psychiatric Services Provider Manual, Chapter IV, under "Assessment"— (Required for Initial Reviews only)

b. Enter the date of the Comprehensive Treatment and Service Plan (Required for First Continued Stay Review only)

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c. Place an X in the box that corresponds to whether or not the locality and clinicians working with the child have determined that TFC-CM services are medically necessary

d. Place an X in the box that corresponds to whether or not two face-to-face contacts between the case manager and the child have occurred each month to ensure the child is receiving safe and effective services. (Required for Continued Stay Review only)

18. Current Behaviors

- In the space provided, for the initial review, provide a narrative of the behavior exhibited by the client over the past 30 days that warrant the requested level of care (please identify frequency, intensity and duration of each behavior). This information should reflect the scoring on the CANS summary sheet. For continued stay, this information should come from the most current 90 day progress report.

19. CANS:

- Enter the date the CANS was completed.
- Provide the scores for each category for both the **Child Behavioral/Emotional Needs** and the **Child Risk Behaviors** sections.

Virginia Locality Codes

CODE	NAME	CODE	NAME	CODE	NAME
001	Accomack	075	Goochland	153	Prince William
003	Albemarle	077	Grayson	155	Pulaski
005	Alleghany	079	Greene	157	Rappahannock
007	Amelia	081	Greensville	159	Richmond
009	Amherst	083	Halifax	161	Roanoke
011	Appomattox	085	Hanover	163	Rockbridge
013	Arlington	087	Henrico	165	Rockingham
015	Augusta	089	Henry	167	Russell
017	Bath	091	Highland	169	Scott
019	Bedford	093	Isle of Wight	171	Shenandoah
021	Bland	095	James City	173	Smyth
023	Botetourt	097	King and Queen	175	Southampton
025	Brunswick	099	King George	177	Spotsylvania
027	Buchanan	101	King William	179	Stafford
029	Buckingham	103	Lancaster	181	Surry
031	Campbell	105	Lee	183	Sussex
033	Caroline	107	Loudoun	185	Tazewell
035	Carroll	109	Louisa	187	Warren
036*	Charles City	111	Lunenburg	191	Washington
037*	Charlotte	113	Madison	193	Westmoreland
041	Chesterfield	115	Mathews	195	Wise
043	Clarke	117	Mecklenburg	197	Wythe
045	Craig	119	Middlesex	199	York
047	Culpeper	121	Montgomery		

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049	Cumberland	125	Nelson
051	Dickenson	127	New Kent
053	Dinwiddie	131	Northampton
057	Essex	133	Northumberland
059	Fairfax	135	Nottoway
061	Fauquier	137	Orange
063	Floyd	139	Page
065	Fluvanna	141	Patrick
067	Franklin	143	Pittsylvania
069	Frederick	145	Powhatan
071	Giles	147	Prince Edward
073	Gloucester	149	Prince George

INDEPENDENT CITIES of Virginia

CODE	NAME	CODE	NAME
510	Alexandria (city)	683	Manassas (city)
515	Bedford (city)	685	Manassas Park (city)
520	Bristol (city)	690	Martinsville (city)
530	Buena Vista (city)	700	Newport News (city)
540	Charlottesville (city)	710	Norfolk (city)
550	Chesapeake (city)	720	Norton (city)
560	Clifton Forge (city)	730	Petersburg (city)
570	Colonial Heights (city)	735	Poquoson (city)
580	Covington (city)	740	Portsmouth (city)
590	Danville (city)	750	Radford (city)
595	Emporia (city)	760	Richmond (city)
600	Fairfax (city)	770	Roanoke (city)
610	Falls Church (city)	775	Salem (city)
620	Franklin (city)	780	South Boston (city)
630	Fredericksburg (city)	790	Staunton (city)
640	Galax (city)	800	Suffolk (city)
650	Hampton (city)	810	Virginia Beach (city)
660	Harrisonburg (city)	820	Waynesboro (city)
670	Hopewell (city)	830	Williamsburg (city)
678	Lexington (city)	840	Winchester (city)
680	Lynchburg (city)		

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