CAMPION, BARROW & ASSOCIATES

Comprehensive Psychological Services

Michael A. Campion, Ph.D, LP, CPQ
Alfred R. Barrow, Ph.D.
OFFICES IN:
Illinois
Indiana
Minnesota

ADMINISTRATIVE OFFICE:
2110 Clearlake Boulevard, Suite 202
Champaign, IL 61822
Phone: (217) 356-9922 / (800) 292-3399
Fax: (217) 356-9875
www.campionbarrow.com

Dear Therapist:

This letter is to introduce you to **The Salvation Army Manage Care Program**. Officers are encouraged to choose their own therapist.

Campion, Barrow and Associates (CBA) serves as a communication link between you, the therapist, and The Salvation Army. **CBA**'s involvement will help ensure confidentiality. We will only report dates of treatment and the ability to function as an officer to the Secretary for Personnel at The Salvation Army Territorial Headquarters.

This packet contains all the necessary forms. The forms may be photocopied, as you need them.

Immediately following are the Manage Care Guidelines for Therapists, forms, and schedules of fees.

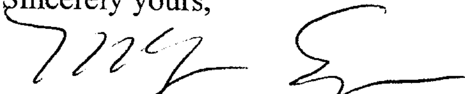
All reports, correspondence, and billings should be mailed under CONFIDENTIAL cover to:

Michael A. Campion, PhD, LP, HSPP, CPQ
Campion, Barrow and Associates
2110 Clearlake Blvd., Suite 202
Champaign IL 61822

Our staff is available to answer questions and support you and the officer. Thank you for your willingness to work with The Salvation Army Officer Assistance and Manage Care Program.

Please call us immediately if you have any questions regarding this program. We have a toll free number for your convenience: (800) 292-3399.

Sincerely yours,



Michael A. Campion, PhD, LP, HSPP, CPQ
CEO/Senior Psychologist
The Salvation Army Manage Care Program

MAC: drb

Packet contents:

- Manage Care Guidelines for Therapists
- Outpatient Intake Summary Form
- Outpatient Summary Form
- Closing Summary Form
- Schedule of Fees

CAMPION, BARROW & ASSOCIATES

The Salvation Army Manage Care Program
Guidelines for Therapist

Therapists providing services to The Salvation Army officers and their family members under the Manage Care program agree to the following procedures and schedule of fees:

1. The officer or family member(s) will have NO CO-PAYMENT OR ADDITIONAL FEES.

2. The therapist agrees to provide services at the rates in accordance with the approved Manage Care rates.

3. Reimbursement for first session:

   - The FIRST session is automatically authorized (at the Manage Care rate).
   - **Authorization must be secured by the officer for continued services.** The officer needs to contact CBA for additional instructions.
   - It is recommended that the therapist contact CBA to confirm authorization prior to scheduling additional services (800) 292-3399.

4. **Pre-certification must be obtained for assessments.** A request, in writing, must be submitted to CBA including the following:

   - Tests to be administered
   - Purpose for testing
   - Standard testing fees

5. Reimbursement for additional treatment is authorized at the conclusion of each additional three (3) sessions **upon receipt of the following documents**:

   - Outpatient Intake Summary (completed at the end of the FIRST visit)
   - Outpatient Summary form (completed at end of subsequent three sessions, until end of therapy)
   - Invoice

6. Final reimbursement will be authorized upon receipt of:

   - Invoice
   - Closing Summary Report

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Manage Care Program

The Salvation Army Central Territory

Outpatient Intake Summary

(Therapist: Please complete this form at the time of the initial visit.)

Patient Name: ______________________________ **Date:** ____________________
Street: ____________________________________ **City:** ______________ **State:** _____ **Zip Code:** _____
Phone: (____) ________________ **Divisional Commander:** ______________________ **Division:** ____________
IDENTIFYING INFORMATION: [Age, sex, marital status, previous psychotherapy, hospitalization, medication, relevant life events]

PRESENTING PROBLEM [Check all that apply.]

- ☐ Problems with spouse or partner
- ☐ Problems with other family member
- ☐ Difficulties at work or school
- ☐ Legal or financial difficulties
- ☐ Psychological difficulties
- ☐ Supervisory referral
- ☐ Alcohol use
- ☐ Drug use
- ☐ Grief/Loss
- ☐ Physical concerns
- ☐ Court directed
- ☐ Other (describe)

CLINICAL INFORMATION Chief Complaint:

Problem Behaviors and Symptoms Treated : **(Indicate "level of severity" 1-5; 1=least severe)**

___ Depressed mood
___ Panic attacks
___ Loose association
___ Sexual dysfunction
___ Appetite disturbance
___ Somatoform disturbance
___ Interpersonal conflicts
___ Poor self-care skills
___ Poor child-care skills
___ Vocational
___ Developmental disorder
___ Hallucinations
___ Poor judgment
___ Gender issues
___ Low self-esteem
___ Avoidant patterns
___ Sleep disturbance
___ Aggressive behaviors
___ Suspected organic issues
___ Poor interpersonal skills
___ Circumstantial/tangential
___ Problems with independent living
___ Lability
___ Delusions
___ Low energy
___ Obsessions
___ Oppositional
___ Stress level
___ Poor insight
___ Conduct issues
___ Impaired memory
___ Learning disability
___ Other (specify) ____________

Alcohol/Substance:	☐ Abuse	☐ Dependence	☐ Substance(s)	____________		
Suicide risk:	☐ Plan	☐ Ideation	☐ History	☐ Specify: ________		
Homicidal risk:	☐ Low	☐ Moderate	☐ High	☐ Specify: ________		
Impulse control:	☐ Low	☐ Moderate	☐ High	☐ Specify: ________		
Suspected/alleged:	☐ Physical abuse	☐ Battering	☐ Sexual abuse	☐ Reported?	☐ Yes	☐ No

Specify: ____

Physical violence risk (if applicable) ☐ Low ☐ Moderate ☐ High
Describe history of violence: ____

How recently? ____

CHECKLIST FOR PSYCHIATRIC CONSULTATION/REFERRAL: Circle Y or N for evidence of each of the following:

Y N A. NEED FOR HOSPITALIZATION
- ☐ Suicidal intent, high lethality
- ☐ Homicidal intent, high lethality
- ☐ Severe impairment of self-care
- ☐ Life threatening medical complication

Y N B. PSYCHOTIC SYMPTOMS
Y N C. ON PSYCHOTTROPIC MEDICATION
Y N D. PATIENT CONCERNED OVER MEDICAL SYMPTOM

Y N E. SUSPECTED ORGANICITY
Y N F. COGNITIVE IMPAIRMENT
Y N G. SIGNS/SYMPTOMS OF DRUG OVERDOSE OR WITHDRAWAL COMPLICATIONS

H. SIGNIFICANT SYMPTOM PRESENTATION
☐ Agitation ☐ Anxiety
☐ Depression ☐ Mania

THERAPIST: ______________________________ **DATE:** ______________________

Please mail form to: CAMPION, BARROW & ASSOCIATES, 2110 Clearlake Blvd, Ste. 202, Champaign IL 61822 Phone: 1-800-292-3399; Fax (217) 356-9875

CAMPION, BARROW & ASSOCIATES

Manage Care Program
The Salvation Army Central Territory

OUTPATIENT SUMMARY

PLEASE COMPLETE AND RETURN.

Please complete this form after each group of three (3) sessions following the initial visit, if treatment is to continue.

Payment for professional services cannot be processed until all necessary reports have been received by CAMPION, BARROW AND ASSOCIATES. If you have any questions, please call 1-800-292-3399.

______________________ (Please type or print clearly) ______________________

Patient Name ______________________________ Age ____________

Street Address ______________________________ Phone (   ) ____________

City ______________ State _____ Zip Code ________

Therapist ______________________________ Highest Level Certification ____________

Street Address ______________________________ Phone ( ) ________

City ______________ State ____________ Zip Code ________

Progress noted: ____

____

____

Treatment Plan for Next Three (3) Sessions: ______________________________

____

____

____

Expected time frame for treatment ______________________________

Professional fee statement enclosed for three (3) sessions. Yes ☐ No ☐

Therapist's Signature ______________________________ Date ______________

FOR OFFICE USE ONLY:

Outpatient Intake Summary completed after first session Yes ☐ No ☐

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Manage Care Program

The Salvation Army Central Territory

Closing Summary Report

(Therapist: Please complete this form at the time of the closing visit.)

Patient Name: ________________________ **Date:** ______________

Street: ________________________ **City:** ______________ **State:** _____ **Zip Code:** ______

Home Phone: (____) ______________ **Work Phone :** (____) ______________ **Division:** ______________

Date of Initial Visit: ______________ **Final Visit:** ______________ **Total # Visits:** __________

CLINICAL INFORMATION Chief Complaint:

Problem Behaviors and Symptoms Treated : **(Indicate "level of severity" 1-5; 1=least severe)**

___ Depressed mood
___ Panic attacks
___ Loose association
___ Sexual dysfunction
___ Appetite disturbance
___ Somatoform disturbance
___ Interpersonal conflicts
___ Poor self-care skills
___ Poor child-care skills
___ Vocational
___ Developmental disorder
___ Hallucinations
___ Poor judgment
___ Gender issues
___ Low self-esteem
___ Avoidant patterns
___ Sleep disturbance
___ Aggressive behaviors
___ Suspected organic issues
___ Poor interpersonal skills
___ Circumstantial/tangential
___ Problems with independent living
___ Lability
___ Delusions
___ Low energy
___ Obsessions
___ Oppositional
___ Stress level
___ Poor insight
___ Conduct issues
___ Impaired memory
___ Learning disability
___ Other (specify) ______________

INITIAL TREATMENT GOALS: **ACHIEVED?**

1. ________________________________ ☐ Yes ☐ No
2. ________________________________ ☐ Yes ☐ No
3. ________________________________ ☐ Yes ☐ No
4. ________________________________ ☐ Yes ☐ No

Treatment Procedure:

____

Number of Sessions: Individual: ___ Group: ___ Couples: ___ Family: ___ Biofeedback: ___ Medications: ___ Other Group Participation: ___

Any Hospitalization: ☐ Yes ☐ No If Yes, where? ______________ Date(s): ________ ________ ________ ________

Patient's Response to Treatment:

____

Reason for Termination: ☐ Treatment goals achieved ☐ Patient viewed treatment as ineffective ☐ Therapist viewed treatment as ineffective ☐ Patient moved away ☐ Patient dropped out

The patient will be able to perform his/her duties as a Salvation Army Officer: ☐ Yes ☐ No

If no, specify: ________________________________

Final Diagnosis: ________________________________

ADDITIONAL CLINCIAL INFORMATION:

Global Assessment of Functioning: Pre-Treatment ______________ Post-Treatment ______________

Medications (specify type & dosage): ________________________________

Unresolved Treatment Problems & Recommendations: ________________________________

____

Community Referrals Made or Referred to: ________________________________

Clinician's Signature: ______________________ Date: ______________

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Manage Care Program

The Salvation Army

2001 Maximum Allowances

PSYCHOLOGIST

(Ph.D. or Psy.D.)

CPT CODE	DESCRIPTION	MAXIMUM ALLOWANCE
90801	Psychiatric Interview	$80.00
90820	Diagnostic Interview	$80.00
90804	Psychotherapy (20-30 min.)	$35.00
90806	Psychotherapy (45-50 min.)	$80.00
90847	Special Family Therapy	$80.00
90853	Special Group Therapy	$25.00
90853	Group/1 hour	$25.00

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Manage Care Program

The Salvation Army

2001 Maximum Allowances

L.C.S.W.

(Licensed, Masters Level)

CPT CODE	DESCRIPTION	MAXIMUM ALLOWANCE
90801	Psychiatric Interview	$65.00
90820	Diagnostic Interview	$65.00
90804	Psychotherapy (20-30 min.)	$25.00
90806	Psychotherapy (45-50 min.)	$65.00
90847	Special Family Therapy	$65.00
90853	Special Group Therapy	$20.00
90853	Group/1 hour	$20.00

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Manage Care Program

The Salvation Army

2001 Maximum Allowances

PSYCHIATRISTS

(M.D.)

CPT CODE	DESCRIPTION	MAXIMUM ALLOWANCE
90801	Psychiatric Interview	$95.00
90802	Diagnostic Interview	$95.00
90804	Psychotherapy (20-30 min.)	$47.50
90805	Psychotherapy (90804) w/ medical eval.	$102.50
90806	Psychotherapy (45-50 min.)	$95.00
90807	Psychotherapy (90806) w/ medical eval.	$150.00
90808	Psychotherapy (75-80 min.)	$142.50
90847	Special Family Therapy	$95.00
90853	Special Group Therapy	$31.50
90858	Group/1 hour	$31.50
90862	Medication Management	$55.00
90887	Interpretation/Explanation	Disallowed
90899	Case Management/Unlisted Services	Disallowed
99221	Initial Hospital Care	$52.50
99222	Initial Hospital Care	$70.00
99231	Subsequent Hospital Care	$55.00
99232	Subsequent Hospital Care	$70.00
99238	Discharge Management	$42.50