**Intensive Behavioral Health Services (IBHS) Written Order Letter**

**Cover Page**

**Child’s Name: Date of Birth:**

**MA ID#: Date or Written Order:**

**Parent/Guardian’s Name(s):**

**School (if applicable):**

**Other agency involvement (if applicable):**

Following my recent face-to-face appointment and/or evaluation on DATE with CHILD, and after considering less restrictive, less intrusive levels of care such as ENTER OTHER LEVELS OF CARE CONSIDERED, I am making the following Written Order.

It is medically necessary that CHILD receive a comprehensive face-to-face assessment for Intensive Behavioral Health Services (IBHS).

Along with this Written Order, I have attached clinical documentation to support the medical necessity of the services ordered, including a current behavioral health disorder diagnosis (listed in the most recent edition of the DSM or ICD), and measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed, or terminated, as per regulations.

**Current Behavioral Health Diagnosis:**

A behavioral health diagnosis is necessary to initiate IBHS. In addition, please include other behavioral health and/or physical health diagnoses or issues of concern, as applicable:

|  |  |
| --- | --- |
| **Behavioral Health Diagnosis (primary)** | **Required- Enter Diagnosis Here** |
| Additional Behavioral Health Diagnosis | Enter Diagnosis Here (repeat row as necessary) |
| Medical conditions/physical health diagnosis | Enter Diagnosis Here (repeat row as necessary) |

**Measurable goals and objectives to be met with IBHS:**

1. List, repeat row as necessary
2. List, repeat row as necessary

**NOTE: This cover page must accompany all submissions of Part A (Initial Written Order) or Part B (Written Order for Continued BHRS/IBHS Treatment) to complete the Written Order.**

**Part A: Initial Written Order for Initial Assessment, Stabilization, and Treatment Initiation**

**A comprehensive, face-to-face assessment is recommended to be completed by an IBHS clinician to further define how the recommendations in this order will be used and to inform and complete an Individualized Treatment Plan (ITP). BHRS/IBHS Treatment Services may also be delivered during the assessment period for stabilization and treatment initiation provided a treatment plan has been developed for the provision of these services.** Please select the assessment type and treatment services necessary for stabilization that you are recommending, based on the symptom(s) and/or behavior(s) of concern and the settings/domains in which they are occurring.

**NOTE: You must complete all sections in one row for a service to be appropriately authorized.**

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| **Service Type** | **Assessment Type /**  **Clinician type** | **Maximum number of hours per month (hpm)**  NOTE: IBHS agency may provide less, as clinically indicated | **Settings in which service is necessary** |
| **ASSESSMENT AND TREATMENT SERVICES PROVIDED BY IBHS PROVIDERS ONLY** | | | |
| IBHS Assessment for Individual,  Group or Evidence-based  Services (For providers with an  IBHS license)  NOTE: Assessment must occur within 15 days of service initiation | IBHS Clinical Assessment by a  MT, BC (may include FBA), or  Graduate Level Professional  (when MST, FFT, PCIT, CRR  HH or an IBHS Group Service) | Episode    Start date, specify: | Home  School, specify:  Community, specify: |
| IBHS-ABA Assessment for ABA  Services (For ABA-Designated  Providers with an IBHS License)  NOTE: Assessment must occur within 30 days of service initiation | IBHS ABA Assessment by a BCBA  or BC-ABA (must include FBA  and/or Skills Assessment) | Episode    Start date, specify: | Home  School, specify:  Community, specify: |
| **ASSESSMENT AND TREATMENT SERVICES PROVIDED BY CURRENT BHRS/ABA/STS PROVIDERS (PER CBH BULLETIN 20-03)** | | | |
| BHRS Assessment for BHRS  Services (For BHRS Providers  without an IBHS license)  NOTE: Assessment must occur within 15 days of service initiation | 400-126: BHRS Clinical Assessment  (may include FBA) and  400-127: BHRS Initial Treatment | Episode    Start date, specify: | Home  School, specify:  Community, specify: |
| BHRS Assessment for BHRS  Services FOR CHILDREN WITH  AN ASD DIAGNOSIS ONLY  NOTE: Assessment must occur within 15 days of service initiation | 400-128: BHRS Clinical Assessment-  Autism (may include FBA) and  400-129: BHRS Initial Treatment-  Autism | Episode    Start date, specify: | Home  School, specify:  Community, specify: |
| BHRS Assessment for ABA  Services (For ABA Designated  Providers without an IBHS  License)  NOTE: Assessment must occur within 30 days of service initiation | 400-130: ABA Clinical Assessment  (must include FBA and/or Skills  Assessment) and  400-131: ABA Initial Treatment-  Autism | Episode    Start date, specify: | Home  School, specify:  Community, specify: |
| STS Assessment for School  Therapeutic Services  NOTE: Assessment must occur within 15 days of service initiation | 400-132: STS Clinical Assessment  and 400-133: STS Initial Treatment | Episode    Start date, specify: | Home  School, specify:  Community, specify: |

**PART A, page 2**

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| **IBHS DIRECT TO TREATMENT SERVICES FOLLOWING AN EVALUATION (i.e., ASSESSMENT AUTH NOT NEEDED)** | | | |
| IBHS Individual Services or  Evidence-Based BHRS Exception  Services | Multi-systemic Therapy (MST)  Functional Family Therapy (FFT)  Mobile Therapist (MT)  Behavior Consultant (BC)  Behavior Health Technician  (BHT)\*  \*NOTE: an FBA is required first | □ Episode  □ Episode  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| IBHS Group Services | IBHS Group Service  Other, specify: | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) other than  the group service site: |
| IBHS ABA Services (For ABA  Designated Providers with  an IBHS License) | Behavior Analytic Services (BCBA)  Behavior Consultation (BC-ABA)  Assistant Behavior Consultation  (Assistant BC-ABA)  Behavioral Health Technician  (BHT-ABA)\*  \*NOTE: an FBA is required first | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| **BHRS/ABA/STS DIRECT TO TREATMENT SERVICES FOLLOWING AN EVALUATION (i.e., ASSESSMENT AUTH NOT NEEDED)** | | | |
| BHRS | Mobile Therapist (MT)  Behavior Specialist Consultant  (BSC)  Therapeutic Support Staff-  School\*  Therapeutic Support Staff-  Non-School\*  \*NOTE: an FBA is required first | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| BHRS- ABA (For ABA  Designated Providers  without an IBHS License) | ABA-Board Certified Behavior  Analyst (ABA-BCBA)  ABA-Behavior Specialist  Consultation (ABA-BSC)  ABA-FBA and/or Skills Assessment  ABA-Therapeutic Support  Staff-School (ABA-TSS-S)\*  ABA-Therapeutic Support  Staff-Non-School (ABA-TSS-NS)\*  \*NOTE: an FBA is required first | Up to \_\_\_ hpm  Up to \_\_\_ hpm  \_\_\_\_ hours total  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| STS | STS Level 1  STS Level 2  STS Level 3 | Start date, specify: | School, specify: |
| BHRS Exceptions | Early childhood treatment program  Social Skills treatment  Clinical Transition & Stabilization  (CTSS-Bethanna)  Wellness & Resiliency -NCS  Summer Therapeutic Program  (STAP or STEP)  Group TSS for summer services  Other, specify: | Up to \_\_\_ hpm  Up to \_\_\_ hpm  □ Episode  □ Episode  □ Episode  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) other than  the group service site: |
| Other Treatment | CRR Host Home  Other, specify: | Start date, specify: | Home  Community, specify:  Other, specify: |

**PART A, page 3**

**Collaboration and Confirmation:**

*I confirm that, following my recent face-to-face appointment and/or evaluation of this child, and after considering less restrictive levels of care, as well as the prioritization of available evidence-based treatments, I am making the recommendations as per the above Written Order.*

Prescriber’s Name (please print): Degree:

License Type: NPI#: PROMISE ID#:

Prescriber’s Signature: Date:

*I confirm that I have participated in the face-to-face appointment and/or evaluation (of my child) and understand the above recommendations for treatment under IBHS. My child’s team discussed the expected level of treatment hours that will be implemented at this time, but I also understand that the number of treatment hours listed above describes the* ***maximum*** *amount that may be received per month over the authorization period that begins now.  I further understand that IBHS treatment hours may vary, based on increasing or decreasing clinical need, whenever changes in location of service are made (such as for summer programming or holidays), and/or the full team’s ongoing assessment of my child’s clinical need.*

Parent/Guardian’s Name (please print):

Parent/Guardian’s Signature: Date:

Youth’s Name (if 14 or older; please print):

Youth’s Signature (if 14 or older): Date:

***If you need to be connected to an IBHS provider in the CBH network, please contact CBH Member Services at 1-888-545-2600.***

**Part B: Written Order for Continued Treatment (Concurrent Review)**

**A comprehensive, face-to-face assessment has been completed by this prescriber and/or an IBHS clinician to define the recommendations in this written order. An Individualized Treatment Plan (ITP) has also been completed, based on the results of the assessment.** Please select which one of the following service types you are recommending, based on the symptom(s) and/or behavior(s) of concern and the settings/domains in which they are occurring.

**NOTE: You must complete all sections in one row for services to be appropriately authorized. If this is the first round of treatment following an Initial Assessment and Treatment auth, please ATTACH the completed Assessment and the ITP to this submission. If this is a request for continued treatment services following 90 days or more of treatment, please ATTACH an updated Progress Review Summary and ITP to establish medical necessity for continued services, per CBH Bulletin 20-02.**

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| --- | --- | --- | --- |
| **Service Type** | **Assessment Type /**  **Clinician type** | **Maximum number of hours per month (hpm)**  NOTE: IBHS agency may provide less, as clinically indicated | **Settings in which service is necessary** |
| **IBHS CONTINUED TREATMENT (for IBHS Providers only)** | | | |
| IBHS Individual Services or  Evidence-Based BHRS Exception  Services | Multi-systemic Therapy (MST)  Functional Family Therapy (FFT)  Mobile Therapist (MT)  Behavior Consultant (BC)  Behavior Health Technician  (BHT)\*  \*NOTE: FBA must be completed or  updated for continued BHT | □ Episode  □ Episode  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| IBHS Group Services | IBHS Group Service  Other, specify: | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) other than  the group service site: |
| IBHS ABA Services (For ABA  Designated Providers with  an IBHS License) | Behavior Analytic Services (BCBA)  Behavior Consultation (BC-ABA)  Assistant Behavior Consultation  (Assistant BC-ABA)  Behavioral Health Technician  (BHT-ABA)\*  \*NOTE: FBA must be completed or  updated for continued BHT | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| **BHRS/ABA/STS CONTINUED TREATMENT** | | | |
| BHRS | Mobile Therapist (MT)  Behavior Specialist Consultant  (BSC)  Therapeutic Support Staff-  School\*  Therapeutic Support Staff-  Non-School\*  \*NOTE: FBA must be completed or  updated for continued TSS | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| BHRS- ABA (For ABA  Designated Providers  without an IBHS License) | ABA-Board Certified Behavior  Analyst (ABA-BCBA)  ABA-Behavior Specialist  Consultation (ABA-BSC)  ABA-FBA and/or Skills Assessment  ABA-Therapeutic Support  Staff-School (ABA-TSS-S)\*  ABA-Therapeutic Support  Staff-Non-School (ABA-TSS-NS)\*  \*NOTE: FBA must be completed or  updated for continued ABA-TSS | Up to \_\_\_ hpm  Up to \_\_\_ hpm  \_\_\_\_ hours total  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| STS | STS Level 1  STS Level 2  STS Level 3 | Start date, specify: | School, specify: |
| BHRS Exceptions | Early childhood treatment program  Social Skills treatment  Clinical Transition & Stabilization  (CTSS-Bethanna)  Wellness & Resiliency -NCS  Summer Therapeutic Program  (STAP or STEP)  Group TSS for summer services  Other, specify: | Up to \_\_\_ hpm  Up to \_\_\_ hpm  □ Episode  □ Episode  □ Episode  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) and  address, if other than  the group service site: |
| Other Treatment | CRR Host Home  Other, specify: | Start date, specify: | Home  Community, specify:  Other, specify: |

**Collaboration and Confirmation:**

*I confirm that, following my recent face-to-face appointment and/or evaluation of this child, and after considering less restrictive levels of care, as well as the prioritization of available evidence-based treatments, I am making the recommendations as per the above Written Order.*

Prescriber’s Name (please print): Degree:

License Type: NPI#: PROMISE ID#:

Prescriber’s Signature: Date:

*I confirm that I have participated in the face-to-face appointment and/or evaluation (of my child) and understand the above recommendations for treatment under IBHS. My child’s team discussed the expected level of treatment hours that will be implemented at this time, but I also understand that the number of treatment hours listed above describes the* ***maximum*** *amount that may be received per month over the authorization period that begins now.  I further understand that IBHS treatment hours may vary, based on increasing or decreasing clinical need, whenever changes in location of service are made (such as for summer programming or holidays), and/or the full team’s ongoing assessment of my child’s clinical need.*

Parent/Guardian’s Name (please print):

Parent/Guardian’s Signature: Date:

Youth’s Name (if 14 or older; please print):

Youth’s Signature (if 14 or older): Date:

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