

Community Behavioral Health

801 Market Street/7th Floor/Philadelphia, PA 19107

215-413-3100

INTENSIVE BEHAVIORAL HEALTH SERVICES (IBHS) WRITTEN ORDER

PROVIDERS: PLEASE COMPLETE ALL FIELDS PRIOR TO SUBMITTING TO CBH

Date: _____

To: **CBH Clinical Management – IBHS team**

From: _____ Your Name _____ Your email _____

_____ Agency Name _____ CBH Provider # _____

_____ Agency Phone _____ Agency Fax _____

Re: _____ Youth Name _____

_____ Parent/Legal Guardian Name _____

_____ Street Address _____ Zip code _____

_____ Home Phone _____ Mobile Phone _____

_____ Primary Email _____ Secondary Email _____

School/Placement Info:

_____ Child’s School (Necessary to identify IBHS regionalized provider)

_____ Other Child Placement (e.g. daycare, Pre-K)

PLEASE CHECK YES OR NO FOR EACH ITEM BELOW:

DHS INVOLVEMENT: No Yes

If yes, name of DHS/CUA Worker: _____

Phone # of DHS/CUA Worker: _____

REGISTERED WITH IDS: No Yes

If yes, name of Supports Coord: _____

Phone # of Supports Coord: _____

COURT INVOLVEMENT: No Yes

If yes, name of PO: _____

Phone # of PO: _____

TPL PLAN OTHER THAN CBH: No Yes If YES, STOP HERE and seek primary authorization or denial through all other payors before submitting to CBH. CBH cannot review any request for IBHS unless CBH is the primary funder.

Is this a request for your agency to staff? No Yes If NO, why not? (e.g., not in cluster, agency doesn’t offer ABA). Reason here: _____

Intensive Behavioral Health Services (IBHS) Written Order

Child's Name: _____ **Date of Birth:** _____

MA ID# (10-digits): _____ **Date of Written Order:** _____

Following my recent face-to-face appointment and/or evaluation on DATE (within last 365 days) with CHILD NAME, 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 NAME receive Intensive Behavioral Health Services (IBHS). This Written Order includes a current, primary 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 IBH Services may be reduced, changed, or terminated, as per regulations.

Additionally, a comprehensive, face-to-face assessment must be completed by an IBHS clinician to further define how the recommendations in this order will be used to inform and complete an Individualized Treatment Plan (ITP). Treatment services by qualified staff may also be delivered during the initial assessment period, provided a treatment plan has been developed for the provision of these services.

Current Behavioral Health Diagnosis:

A primary 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:

Primary Behavioral Health Diagnosis: Enter Diagnosis Here
Additional Behavioral Health Diagnosis: (repeat row as necessary)
Medical conditions/physical health diagnosis: (repeat row as necessary)

Measurable goals and objectives to be met with IBHS, and which justify the medical necessity of the types and amounts of services prescribed in this Written Order:

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

Please select the services that you are recommending, based on the symptoms/behaviors of concern and the setting(s) in which services may occur. You must complete all sections in one or two rows for a service to be appropriately authorized. **All treatment authorizations will align with program description or be given for 365 days, unless otherwise specified. Start date will be date reviewed, unless otherwise specified.**

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 may be necessary
IBHS INITIAL ASSESSMENT AND TREATMENT SERVICES			
<input type="checkbox"/> IBHS Initial Assessment and Treatment for Individual or Group Services	<input type="checkbox"/> 425-4 (Assessment) and 425-5 (Initial Treatment)	<input type="checkbox"/> Episode – 15 days (up to 400 units) assessment and 30 days (up to 1,500 units) treatment Start date, specify:	<input type="checkbox"/> Home <input type="checkbox"/> School, specify: <input type="checkbox"/> Community, specify:
<input type="checkbox"/> IBHS-ABA Initial Assessment and Treatment for ABA Services	<input type="checkbox"/> 425-6 (Assessment-ABA) and 425-7 (Initial Treatment-ABA)	<input type="checkbox"/> Episode – 30 days (up to 750 units) assessment and 45 days (up to 2,500 units) treatment Start date, specify:	<input type="checkbox"/> Home <input type="checkbox"/> School, specify: <input type="checkbox"/> Community, specify:
IBHS DIRECT TO TREATMENT SERVICES			
<input type="checkbox"/> IBHS Individual Services (Child to be served by Regionalized IBHS provider, per school cluster)	<input type="checkbox"/> Behavior Consultant (BC) <input type="checkbox"/> Mobile Therapist (MT) <input type="checkbox"/> Behavior Health Technician (BHT)* *NOTE: an FBA is required first	Up to ___ hpm Up to ___ hpm Up to ___ hpm Start date, specify:	<input type="checkbox"/> Home <input type="checkbox"/> School, specify: <input type="checkbox"/> Community, specify: <input type="checkbox"/> Center-based location, specify:
<input type="checkbox"/> IBHS Group Services *NOTE: Members may receive Group in addition to IBHS-Individual Services (row above)	<input type="checkbox"/> Group Mobile Therapist (GMT)	Up to ___ hpm Start date, specify:	<input type="checkbox"/> School, specify: <input type="checkbox"/> Community, specify: <input type="checkbox"/> Center-based location, specify:
<input type="checkbox"/> IBHS ABA Individual Services	<input type="checkbox"/> Behavior Analytic Services (BCBA) <input type="checkbox"/> Behavior Consultation (BC-ABA) <input type="checkbox"/> Assistant Behavior Consultation (Assistant BC-ABA) <input type="checkbox"/> 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:	<input type="checkbox"/> Home <input type="checkbox"/> School, specify: <input type="checkbox"/> Community, specify: <input type="checkbox"/> Center-based location, specify:
<input type="checkbox"/> IBHS ABA Group Services *NOTE: Members may receive ABA Group in addition to ABA-Individual Services (row above)	<input type="checkbox"/> Group ABA Services	Up to ___ hpm Start date, specify:	<input type="checkbox"/> School, specify: <input type="checkbox"/> Community, specify: <input type="checkbox"/> Center-based location, specify:

IBHS EVIDENCE-BASED AND SPECIALIZED PROGRAMS			
<input type="checkbox"/> ABA Early Childhood Intensive Services *NOTE: ABA EC are stand-alone services, cannot co-occur with other IBHS	<input type="checkbox"/> ABA Early Childhood Intensive Services	<input type="checkbox"/> Episode Start date, specify:	<input type="checkbox"/> Community, specify: <input type="checkbox"/> Center-based location, specify:
<input type="checkbox"/> IBHS Evidence-Based Therapies	<input type="checkbox"/> Functional Family Therapy (FFT) <input type="checkbox"/> Multi-systemic Therapy (MST)* <input type="checkbox"/> Multi-systemic Therapy - Problem Sexual Behavior (MST-PSB)* *NOTE: a referral, Psych Eval and Initial ISPT are also required	<input type="checkbox"/> Episode <input type="checkbox"/> Episode <input type="checkbox"/> Episode Start date, specify:	<input type="checkbox"/> Home <input type="checkbox"/> School, specify: <input type="checkbox"/> Community, specify:
<input type="checkbox"/> IBHS Other – CTSS	<input type="checkbox"/> Clinical Transition & Stabilization (CTSS @ Bethanna)	<input type="checkbox"/> Episode, 90 days, up to 40 hpw/160 hpm	<input type="checkbox"/> All environments where stabilization is needed, including home, school, and community

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. I further confirm that I have communicated these recommendations for treatment to the youth, youth’s parents, and/or legal guardians in a language easily understood by all. I explained that the number of treatment hours listed above describes the **maximum** amount that can be received per month over the authorization period that begins now. Finally, I informed the youth and their parent/legal guardian 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 clinical need.*

Prescriber’s Name (please print): _____ Degree: _____

License Type: _____ NPI#: _____ PROMISE ID#: _____

Prescriber’s Signature: _____ Date: _____

Prescriber’s Email Address: _____

***NOTE: ALL fields above required. Failure to submit a complete form may result in CBH marking this request as Insufficient and/or denying the request.**

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