Updated: 03/23/2023

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**

_St. Christopher's Hospital for Children 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:_____

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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

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

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