DEPARTMENT OF HUMAN SERVICES

DHS-6322A-ENG 1-23

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Additional Dialectical Behavior Therapy (DBT) Intensive Outpatient Program (IOP) Authorization

ASSIGNED NUMBER FROM MN–ITS
EXISTING PRIOR AUTHORIZATION NUMBER

Submit this completed form to the medical review agent. Refer to the Authorization section of the MHCP Provider Manual.

Review the Initial Dialectical Behavior Therapy (DBT) Intensive Outpatient Program (IOP) Authorization (DHS-6322) (PDF) for definition and eligibility criteria.

Complete this form if DBT treatment is currently in progress to request authorization for continued DBT services. The conclusion of the summary determines a member is likely to benefit from continued DBT treatment and that progress is being made toward discharge or a lower level of care.

Member Information

MEMBER LAST NAME	FIRST NAME	MI	MHCP MEMBER ID NUMBER

DATE OF CURRENT DIAGNOSTIC ASSESSMENT	DATE OF CURRENT FUNCTIONAL ASSESSMENT

Complete the Rationale for concurrent exclusionary service section if DBT is being provided concurrently with an adult or adolescent exclusionary service. Include in the rationale a coordinated plan that addresses length of time and the expected outcome of the following concurrent exclusionary services:

Exclusionary Services (Adult)

- Partial hospitalization
- Outpatient psychotherapy
- Day treatment
- Assertive Community Treatment (ACT)

Exclusionary Services (Adolescent)

- Outpatient individual psychotherapy (including under Children's Therapeutic Services and Supports [CTSS] umbrella)
- Partial Hospitalization
- CTSS Children's Day Treatment
- Intensive Treatment in Foster Care
- Youth Assertive Community Treatment (Youth ACT)

Rationale for concurrent exclusionary service

Describe medical necessity for providing concurrent DBT and partial hospitalization, day treatment, outpatient psychotherapy, Intensive Treatment in Foster Care or Youth ACT.

Treatment Duration

EXPECTED DURATION OF DBT TREATMENT FROM: TO:	DISCHARGE CRITERIA IF DISCHARGE IS ANTICIPATED IN THIS AUTHORIZATION PERIOD (within 6 months)
DISCHARGE DATE	EXPECTED CHANGES IN FUNCTION FROM DBT INVOLVEMENT

Member must meet all criteria in boxes 1–4 for additional authorization of DBT treatment.

1. The member is actively participating and engaged in the DBT program, its treatment components and guidelines according to treatment team expectations.

DESCRIBE MEMBER'S PARTICIPATION AND ENGAGEMENT IN TREATMENT

2. The member shows demonstrable progress as measured against the member's baseline level of functioning before DBT intervention. Examples of demonstrable progress may include:
   - Decrease in self-destructive behaviors
   - Decrease in acute psychiatric symptoms with increased functioning in activities of daily living
   - Reduction in number of acute care services, such as emergency department visits, crisis services, hospital admission
   - Showing objective signs of increased engagement
   - Applying skills learned in DBT to life situations

DESCRIBE MEMBER'S PROGRESS

3. The member continues to make progress toward goals but has not fully demonstrated an ability to self-manage and use learned skills effectively.

DESCRIBE EVIDENCE OF CONTINUED NEED FOR SKILL ACQUISITION AND PRACTICE

4. The member is actively working toward discharge.

DESCRIBE CONCRETE PLANNING FOR TRANSITION AND DISCHARGE

Provider Statement

A member of the certified DBT program, either a mental health professional or a supervised clinical trainee, must review information and complete this authorization form. The mental health professional is required to review all documentation that any mental health practitioner working as a clinical trainee submits when completing the assessments and authorization form.

I certify that the information provided on this form is accurate, complete and truthful. I will notify MHCP of any changes to this information.

I acknowledge that any misrepresentations in the information submitted to MHCP, including false claims, statements, documents, or concealment of a material fact, may be cause for denial or termination of participation as a Medicaid provider.

PROVIDER NAME (type or print clearly)	TITLE	
PROVIDER SIGNATURE (required)		DATE

Supporting Documentation for Additional Authorization Request

With this additional DBT authorization request, include the following:

- ☐ The member's current **diagnostic assessment or update**, only if significant changes were made since the initial DBT authorization request. A DA is considered current when completed in the previous 12 months.
- ☐ The member's most **recent functional assessment**. A functional assessment is required every six months.
- ☐ Individual treatment plans must be updated every 180 days.
- ☐ Four individual and four group skills progress notes (a total of eight progress notes) since the initial authorization that indicate progress made and the ongoing goals for DBT treatment.