DHS-6322A-ENG 2-12

Minnesota Health Care Programs (MHCP)

Additional Dialectical Behavior Therapy (DBT) Authorization Form

Review the Initial DBT Authorization Form (DHS-6322) for definition and eligibility criteria.

ASSIGNED NUMBER FROM MN–ITS	EXISTING PRIOR AUTHORIZATION NUMBER

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

Enter all dates in MM/DD/YYYY format.

Recipient Information

RECIPIENT LAST NAME	FIRST NAME	MI	MHCP RECIPIENT ID #

DATE OF CURRENT DIAGNOSTIC ASSESSMENT	DATE OF CURRENT FUNCTIONAL ASSESSMENT

Exclusionary Services

If DBT is being provided concurrently with an exclusionary service, complete the rationale section below. Rationale includes a coordinated plan addressing length of time and expected outcome of concurrent exclusionary service provision.

- Partial hospitalization
- Outpatient psychotherapy
- Day treatment

RATIONALE FOR CONCURRENT EXCLUSIONARY SERVICE Describe medical necessity for providing concurrent DBT and partial hospitalization, day treatment, outpatient psychotherapy, psychotherapy group or inpatient hospital.

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	

All criteria must be met in boxes 1 - 4 for additional authorization of DBT treatment.

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

DESCRIBE RECIPIENT'S PARTICIPATION AND ENGAGEMENT IN TREATMENT

2. The recipient shows demonstrable progress as measured against the recipient'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 RECIPIENT PROGRESS

3. The recipient 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 recipient is actively working toward discharge.

DESCRIBE CONCRETE PLANNING FOR TRANSITION AND DISCHARGE

Provider Statement

The review of information and authorization form needs to be completed by a member of the certified DBT program, either by a mental health professional or a supervised clinical trainee. The mental health professional is required to review all documentation submitted by any mental health practitioner working as a clinical trainee completing the assessments and authorization form.

I certify that the information provided on this form is accurate, complete and truthful. I will notify MHCP Provider Enrollment 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 recipient's current **diagnostic assessment or update**, only if there have been significant changes since the initial DBT authorization request. A DA is considered current when completed in the previous 12 months.
- ☐ The recipient's most **recent functional assessment**.
- ☐ The **updated treatment plan** with ongoing goals for DBT treatment. (The treatment plan OR one month of progress notes must indicate progress/status of each goal from previous review period.)
- ☐ The LOCUS Recording Form (DHS-6249), if available.