



Minnesota Department of **Human Services**

Complete this authorization request in addition to completing the MN–ITS Authorization Request (278) or Authorization Form (DHS-4695). Fax this form with any additional or required documentation to the [medical review agent](#).

Dialectical Behavior Therapy (DBT) Intensive Outpatient Program (IOP) services require authorization for up to six months of service. If continued treatment is necessary beyond the initial six months of authorized treatment, request additional authorization (see DHS-6322A) based on continued stay criteria. All services authorized must be provided by a DBT program certified by the Minnesota Department of Human Services (DHS).

A recommendation for DBT IOP must be based on a comprehensive assessment, including: a diagnostic assessment, a functional assessment and a review of the recipient's prior treatment history by the DBT team, to determine that DBT outpatient services are medically necessary.

To be eligible to receive DBT IOP services, a recipient must meet all the following criteria:

- Be 18 years of age or within 3 months of becoming age 18
- Have a diagnosis of borderline personality disorder or
- Have multiple mental health diagnoses and
 - Exhibit behaviors characterized by impulsivity and/or exhibit intentional self-harm behavior and
 - Be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas
- Have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services
- Be at risk of one of the following, as recorded in the recipient's record:
 - A higher level of care, such as hospitalization or partial hospitalization
 - Intentional self-harm (suicidal and non-suicidal) or risky impulsive behavior or is currently having chronic self-harm thoughts or urges (suicidal or non-suicidal) although the recipient has managed to not act on them; recipients with chronic self-harm thoughts and urges are at a greater risk of decompensation
 - A mental health crisis
 - Decompensation of mental health symptoms; a change in recipient's composite LOCUS score, though not required, demonstrates risk of decompensation
- Understand and be cognitively capable of participating in DBT as an intensive therapy program
- Be able and willing to follow program policies and rules assuring the safety of self and others



Minnesota Health Care Programs (MHCP)

Initial Dialectical Behavior Therapy (DBT) Authorization Form

Recipient Information

Enter dates only in MM/DD/YYYY format.

ASSIGNED NUMBER FROM MN-ITS MHCP RECIPIENT ID #

Form with fields for RECIPIENT LAST NAME, FIRST NAME, MI, DATE OF CURRENT DIAGNOSTIC ASSESSMENT/UPDATE, DATE OF CURRENT FUNCTIONAL ASSESSMENT/UPDATE, and a table for DIAGNOSIS (AXIS I-V).

Recipient has three or more areas of functional impairment. [] Yes [] No

Mental Health Service History

Complete the following information for the past 12 months.

Table with columns: Mental Health Service, Dates of Service (FROM, TO), and three additional columns for Dates of Service (FROM, TO). Rows include Individual Psychotherapy, Partial Hospitalization, MH Crisis Response Services, Group Psychotherapy, Family Psychotherapy, Medication Management, ACT, Emergency Services, Inpatient Hospitalization, Day Treatment, IRTS, ARMHS, Other DBT - DESCRIBE:, and Other - DESCRIBE:.

Care coordinated with current service providers. [] Yes [] No

ASSIGNED NUMBER FROM MN-ITS	MHCP RECIPIENT ID #
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Exclusionary Services

If DBT is being provided concurrently with an exclusionary service, complete the rationale section below. Rationale should include 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	

Check all that apply

- The LOCUS score is available.

CURRENT COMPOSITE LOCUS SCORE	DATE OF CURRENT COMPOSITE LOCUS SCORE (within 30 days)
PREVIOUS COMPOSITE LOCUS SCORE	DATE OF PREVIOUS COMPOSITE LOCUS SCORE (30 days or more)
INDICATE INTERVENTIONS TO ENSURE RECIPIENT'S SAFETY IF LOCUS SCORE IS 4 OR HIGHER	

- Recipient has a low IQ, a diagnosed TBI or other cognitive disability.

DESCRIBE HOW YOU WILL ADAPT YOUR TEACHING STYLE AND BEHAVIORAL INTERVENTIONS TO BE ABLE TO PROVIDE THEM WITH DBT IOP

Provider Statement

The review of information and authorization forms must 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 clinical trainee completing the assessments and authorization forms.

<p>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.</p> <p>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.</p>	
PROVIDER NAME (type or print clearly)	TITLE
PROVIDER SIGNATURE (required)	DATE

Supporting Documentation for Initial Authorization

With this initial DBT request, include the following:

- The recipient's current **diagnostic assessment (DA) or diagnostic update**, conducted by a mental health professional or a mental health practitioner working as a clinical trainee and reviewed by the supervisor. A DA is considered current when completed in the previous 12 months.
- The recipient's most **recent functional assessment (FA)**. You may use an FA completed by another service provider within the last six months if the information reflects current functioning. The FA must address 14 domains of life areas (mental health symptoms, mental health service needs, use of drugs/alcohol, vocational functioning, educational functioning, social functioning, interpersonal functioning, self-care and independent living skills, medical health, dental health, maintaining financial, obtaining and maintaining housing). The functional assessment should not be based on historical or predicted functions.
- The recipient's **personal commitment/contract** to enter the DBT program. To be eligible to receive the service of DBT IOP the recipient must agree to the extended time period needed to address life threatening and therapy interfering behaviors and to acquire necessary skills to improve quality of life. DBT IOP requires that an individual acquire related skills in a group setting. If skills teaching cannot occur in a group setting, include within the agreement or treatment plan the alternative arrangement for recipient acquiring DBT skills. The recipient must be able and willing to follow all program policies and rules assuring safety of self and others within all components of DBT IOP.
- The recipient **treatment plan** that includes goals for stage one DBT treatment.
- LOCUS Recording Form (DHS-6249), if available.