Magellan Behavioral Health of Pennsylvania, Inc.
Intensive Behavioral Health Services (IBHS)
Written Order Template

Directions

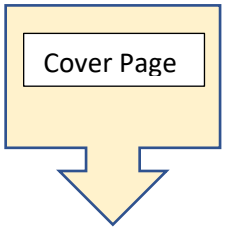
Per the Intensive Behavioral Health Services (IBHS) regulations, the Written Order is based on a face-to-face interaction with the child, youth or young adult that meets the following:

1. Written within 12 months prior to the initiation of IBHS
2. Written by a licensed physician, licensed psychologist, certified registered nurse practitioner or other licensed professional whose scope of practice includes the diagnosis and treatment of behavioral health disorders and the prescribing of behavioral health services including IBHS
3. Includes a behavioral health disorder diagnosis
4. Clinical information to support the medical necessity of the service ordered
5. The maximum number of hours of each service per month
6. The settings where services may be provided
7. The measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed, or terminated

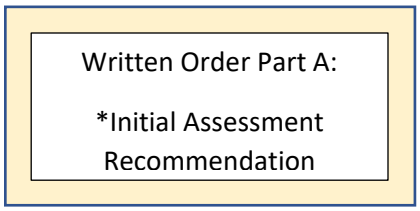
Directions:

- ✓ Cover Page – Must be completed with all Written Order recommendations
- ✓ Part A: Initial Assessment Recommendation – Please complete if this is a Written Order for a member not currently involved with IBHS and needing an initial assessment.
- ✓ Part B: IBH Service Recommendation – Please complete this part to recommend IBH services.

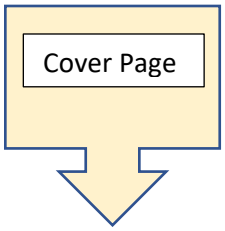
Brand <u>New Member</u> Presenting for IBH Services

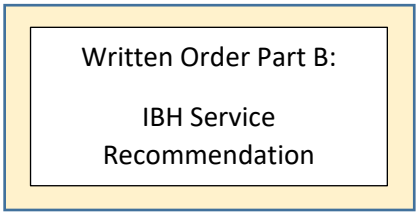


Assessments are required to be completed as part of the process to initiate an IBH service



Recommendation for IBH Services





*Optional: IBHS Treatment Services may also be delivered during the assessment period for stabilization and treatment initiation provided a treatment plan has been developed for the provision of these services. If choosing this option, please complete Part A for Service Assessment Type as well as Part B to recommend treatment service

Magellan Behavioral Health of Pennsylvania, Inc.
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Written Order Letter
COVER PAGE

This cover page must accompany Part A (Initial Assessment Recommendation) or Part B (IBH Service Recommendation) to complete the Written Order.

Member's Name: _____ Date of Birth: _____

Medical Assistance ID #: _____ Date of Written Order: _____

County of Residence: _____

Parent/Guardian's Name(s): _____

School (If Applicable): _____

Other Agency Involvement (If Applicable): _____

_____

Following my recent face-to-face appointment and/or evaluation on _____ with _____ and after considering less restrictive, less intrusive levels of care such as _____ I am making the following order:

It is medically necessary that _____ receive a comprehensive face-to-face assessment for IBHS.

Along with this Written Order, I have included clinical documentation to support the medical necessity of the services ordered, including a 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 services may be reduced, changed, or terminated, as per regulations.

Current Behavioral Health Diagnosis:

A 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 (Reference Mixed Services Protocol List here: https://www.magellanprovider.com/getting-paid/preparing-claims/icd10-code-transition.aspx):

Primary Behavioral Health Diagnosis: _____

Additional Behavioral Health Diagnosis: _____

Additional Behavioral Health Diagnosis: _____

Additional Behavioral Health Diagnosis: _____

Medical Conditions/Physical Health Diagnosis: _____

Medical Conditions/Physical Health Diagnosis: _____

Medical Conditions/Physical Health Diagnosis: _____

List measurable improvements in targeted behaviors or skill deficits that indicate when services may be reduced, changed, or terminated:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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Magellan Behavioral Health of Pennsylvania, Inc.
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COVER PAGE

Clinical Information that supports the Medical Necessity of the Order:

List Current Medications and Dosage:

1. _____
2. _____
3. _____
4. _____
5. _____

Magellan Behavioral Health of Pennsylvania, Inc.
Intensive Behavioral Health Services (IBHS)
Written Order Template
Part A: IBHS Initial Assessment Recommendation

Assessments are required to be completed as part of the process to initiate an IBH service.
PART A: Check the Service Assessment Type that is needed. Also complete the signature information on the last page.

	Service Assessment Type		Assessment Hours/Timeframes
☐	Initial Assessment for IBHS Individual	☐	IBHS-15 hours for 30 days **NOTE**: Assessment must occur within 15 calendar days of service initiation.
☐	Initial Assessment for IBHS Group	☐	IBHS-15 hours for 30 days **NOTE**: Assessment must occur within 15 calendar days of service initiation.
☐	Initial Assessment for IBHS ABA Services	☐	IBHS ABA-24 hours for 45 days **NOTE**: Assessment must occur within 30 calendar days of service initiation for ABA.
☐	Initial Assessment for MST	☐	MST-25 hours for 30 days **NOTE**: Assessment must occur within 15 calendar days of service initiation.
☐	Initial Assessment for FFT	☐	FFT-7.5 hours for 30 days **NOTE**: Assessment must occur within 15 calendar days of service initiation.

Optional: IBHS Treatment Services may also be delivered during the assessment period for stabilization and treatment initiation provided a treatment plan has been developed for the provision of these services. If choosing this option, please complete Part A for Service Assessment Type as well as Part B to recommend treatment services.

Collaboration and Confirmation

Prescriber:
I confirm that following my 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.

Prescriber's Name: _____ Degree: _____

Prescriber's Phone #: _____ Prescriber's Email: _____

Prescriber's Address: _____ City: _____ State: _____ Zip: _____

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

Prescriber's Signature: _____ Date: _____

Parent/Guardian: (Optional)
I confirm that I have participated in the face-to-face appointment and/or evaluation (of my child) and understand the above recommendations for further assessment and, if applicable, treatment initiation for stabilization under IBHS. I understand that the treatment hours listed above describe the maximum amount to be received per month and that IBHS treatment hours may vary, based on clinical need and ongoing assessment.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

Youth's Name if 14 or Older: _____

Youth's Signature if 14 or Older: _____ Date: _____

If you need to be connected to an IBHS provider in the Magellan network, please contact Magellan Member Services at:
Bucks: (877) 769-9784 **Lehigh: (866) 238-2311** **Montgomery: (877) 769-9782**
Cambria: (800) 424-0485 **Northampton: (866) 238-2312**

Magellan Behavioral Health of Pennsylvania, Inc.
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Part B: IBH Service Recommendation

PART B: *Directions: Please select the IBH Service Category or Categories, and the specific IBH Service Type(s) within each category that are medically necessary for the child, youth, or young adult based on symptom(s) and/or behavior(s) of concern. For each service type recommended, please indicate the maximum number of hours per month (or episode if relevant) based on severity of symptoms/behaviors, and the specific setting(s) in which treatment should occur. NOTE: All sections in the same row must be completed for a service to be appropriately authorized.*

Intensive Behavioral Health Service Categories		IBH Service Types	Maximum number of hours per month *(Note: The IBHS agency may provide less as clinically indicated)*	Settings in which treatment is necessary
IBHS Individual	☐	Behavior Consultant (BC)	Up to _____ hours per month	☐ Home ☐ School ☐ 1:1 Center-based ☐ Community (specify location): _____
	☐	Mobile Therapist (MT)	Up to _____ hours per month	
	☐	Behavioral Health Technician (BHT)	Up to _____ hours per month	
IBHS ABA	☐	Behavior Consultant – ABA (BC-ABA)	Up to _____ hours per month	☐ Home ☐ School ☐ 1:1 Center-based ☐ Community (specify location): _____
	☐	Behavioral Health Technician – ABA (BHT-ABA)	Up to _____ hours per month	
IBHS Group			Up to _____ hours per month	
IBHS ABA Group			Up to _____ hours per month	
IBHS Evidence-Based Therapy (EBT)	☐	Multisystemic Therapy (MST)	Up to _____ hours per month	☐ Home ☐ School ☐ 1:1 Center-based ☐ Community (specify location): _____
	☐	Functional Family Therapy (FFT) ** Only available in certain counties*	Up to _____ hours per month	
IBHS Specialty Program ** Not provided by all agencies and in all locations*		**Brief Treatment Model**		
	☐	Behavior Consulting	Up to _____ hours per month	
	☐	Mobile Therapy	Up to _____ hours per month	
	☐	**KidsPeace SITE**	Up to _____ hours per month	
		Intensive Family Coaching		☐ Home ☐ School ☐ 1:1 Center-based ☐ Community (specify location): _____
	☐	Mobile Therapist	Up to _____ hours per month	
	☐	Behavior Health Technician	Up to _____ hours per month	

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Part B: IBH Service Recommendation

Collaboration and Confirmation

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Prescriber's Name: _____ Degree: _____

Prescriber's Address: _____ City: _____ State: _____ Zip: _____

Prescriber's Phone #: _____ Prescriber's Email: _____

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

Prescriber's Signature: _____ Date: _____

Parent/Guardian: (Optional)
I confirm that I have participated in the face-to-face appointment and/or evaluation (of my child) and understand the above recommendations for further assessment and, if applicable, treatment initiation for stabilization under IBHS. I understand that the treatment hours listed above describe the maximum amount to be received per month and that IBHS treatment hours may vary, based on clinical need and ongoing assessment.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

Youth's Name if 14 or Older: _____

Youth's Signature if 14 or Older: _____ Date: _____

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