Clear Form

Minnesota Department of **Human Services** DHS-4159-ENG 10-11

Children's Therapeutic Services and Supports

Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for CTSS. **Complete online**, print and fax this form with any additional or required documentation to the medical review agent. See instructions for completing this form.

Provider Information

PROVIDER NAME

AGENCY NPI

CONTACT NAME

PHONE NUMBER

Recipient Information

LAST NAME | FIRST NAME | MI | DATE OF BIRTH | MHCP RECIPIENT ID NUMBER

Allowed maximum units have been used before requesting authorization. ◯ Yes ◯ No

Authorization threshold will be met within next 10 business days. ◯ Yes ◯ No

Recipient's diagnosis

DATE OF CURRENT DIAGNOSTIC ASSESSMENT (DA) (must attach)

DA ATTACHED ◯ Yes ◯ No

DATE OF CURRENT FUNCTIONAL ASSESSMENT (FA) IF DIFFERENT THAN DA (must attach)

FA RESULT ATTACHED ◯ Yes ◯ No

PRIMARY DIAGNOSIS CODE (not DSM) | DESCRIPTION

SECONDARY DIAGNOSIS CODE (not DSM) | DESCRIPTION

DATE AND HISTORY OF ONSET/EXACERBATION OF EACH DIAGNOSIS LISTED ABOVE

Treatment

Treatment plan (Attach individualized treatment plan that contains the following: treatment goals, treatment objectives, outcomes)

Prior mental health service history (Past 12 months) Check all that apply.

- ☐ Individual psychotherapy
- ☐ Family psychotherapy
- ☐ Group psychotherapy
- ☐ Individual skills
- ☐ Family skills
- ☐ Group skills
- ☐ Crisis assistance
- ☐ Day treatment
- ☐ Therapeutic preschool
- ☐ Direction of MHBA
- ☐ Mental health behavioral aide
- ☐ Medication management
- ☐ Partial hospitalization
- ☐ Inpatient hospitalization
- ☐ Children's residential treatment
- ☐ Crisis response services

Service Planning

FREQUENCY OF REQUESTED SERVICES, INCLUDING SCHEDULE OF DECLINING FREQUENCY IN RELATION TO THERAPEUTIC GOALS FOR THIS AUTHORIZATION PERIOD. Indicate, by procedure code, number of hours of service per day and frequency (e.g., daily by number of days per week, weekly, monthly, quarterly, etc.) of these services.

DISCHARGE CRITERIA. Indicate recipient's overall discharge plan and expected date of achievement.

PROJECTED DISCHARGE DATE

RATIONALE FOR ADDITIONAL UNITS OF SERVICE. Describe medical necessity for continued service.

Other services

If recipient is receiving any of the following services, indicate the **number of hours** of service per day and the **frequency** of the services:

Service	No. of hours	Frequency
Community Alternatives for Disabled Individuals (CADI) Waiver		
Development Disabilities (DD) Waiver		
Family psychotherapy (non-CTSS)		
Group psychotherapy (non-CTSS)		
Individual psychotherapy (non-CTSS)		
Medication management		

Mental Health - Targeted Case Management (MH-TCM)		
Personal Care Assistant (PCA)		
Special Education Services and/or School CTSS		

Other service	Explain	
		X

+

MENTAL HEALTH PROFESSIONAL SIGNATURE

DATE

Instructions for Children's Therapeutic Services and Supports Authorization Form

This supplemental form is designed to assist providers in ensuring sufficient documentation is made available to establish medical necessity when a request for authorization is submitted by the provider. Unnecessary delays and possible denial of request is prevented by completing this form, ensuring recipient is covered under MHCP FFS, and submitting the required documentation. Authorization for service is sought when diagnostic assessment, individualized treatment plan and CASII or SDQ or ECSII indicate the need for additional medically necessary services.

See Minnesota Health CarePrograms Provider Manual - Mental Health Services for additional information on authorization requests.

Provider Information

Provider Name: Add provider name used for CTSS claiming.

NPI/UMPI: Indicate NPI/UMPI used for CTSS.

Contact Name: Indicate the name of person who can answer questions about this form.

Phone Number: Indicate the phone number for person listed as contact.

Recipient information

Recipient Name: Indicate the name as identified on Minnesota Health Care Programs Card.

Date of birth: Recipient's date of birth.

MHCP ID Number: Insert number as identified on Minnesota Health Care Programs Card.

Review authorization threshold tables prior to answering questions.

CTSS Authorization Table

CTSS Day Treatment Authorization

Recipient diagnosis

Recipient's diagnosis: List the date of the most current diagnostic assessment and functional assessment. Attach the most current diagnostic assessment and functional assessment result.

List the appropriate ICD diagnosis code(s) for primary and secondary diagnoses. Include other diagnoses as appropriate in description section. *Remember that under CTSS a yearly diagnostic assessment is required for patients 0 to 18 years old unless the recipient meets the criteria in Minnesota Statutes 256B.0943 subdivision 3, item (5).*

Date and history: Provide information on the date and history of onset/exacerbation of each diagnosis pertaining to this request.

Treatment

Treatment plan: Attach a copy of the individual treatment plan (ITP) for the request period and two prior plans (if the recipient received services from you prior to this request) that are relevant to this request. *Remember that the ITP must contain short-term and long-term goals and measurable objectives specific to this recipient.*

Treatment goals: Indicate expected outcome and prognosis from service(s) being requested.

Treatment objectives: For each of the measurable objectives identified in the ITP identify the intervention/ method for achieving the objective, the progress to date in achieving the objective and the targeted resolution date.

Outcomes: Identify the outcomes to be met along with the services and supports to be established.

Prior mental health service history: Check box for any mental health services that the client received in the past 12 months. Indicate time range when service was received. Attach a copy of progress notes for the past six (6) sessions. Unless the request is for a retro period, then attach notes since beginning of request period.

Service planning

Frequency of requested services: Indicate by procedure code the number of hours of service per day and the frequency (for example, daily by number of days per week, weekly, monthly, quarterly, etc.) of these services.

Discharge criteria and projected date: Indicate the recipient's overall discharge plan and the expected date of achievement.

Rationale for additional units of service: Describe medical necessity for continued service.

Other services

If a recipient is receiving one of these services, indicate the number of hours of service per day and the frequency (for example, daily, weekly, monthly, quarterly, etc.) of the service. If the recipient is receiving a service not indicated above that effects their mental health treatment, identify the service in other and explain its affect.