Office of Medicaid Innovation

University of Illinois System

Altogether Extraordinary™

Prior Authorization Request Form
Individual and Therapeutic Support Services

March 2024

Section 1. Youth Information

1. Youth Name. Enter the first and last name of the youth seeking the service.

Section 1. Youth Information		
Youth Name:	Date of Birth:	RIN:
Primary Diagnosis:		ICD-10 Code:
Program Enrollment (check all that apply): ☐ **Pathways** ☐ **FSP** ☐ **SFSP**		

Section 1. Youth Information

2. Date of Birth. Enter the date of birth of the youth seeking the service.

Section 1. Youth Information		
Youth Name:	Date of Birth:	RIN:
Primary Diagnosis:		ICD-10 Code:
Program Enrollment (check all that apply): ☐ **Pathways**	☐ **FSP**	☐ **SFSP**

Section 1. Youth Information

3. RIN. Enter the State of Illinois recipient identification number (RIN) of the youth seeking the service.

Section 1. Youth Information		
Youth Name:	Date of Birth:	RIN:
Primary Diagnosis:		ICD-10 Code:
Program Enrollment (check all that apply): ☐ **Pathways** ☐ **FSP** ☐ **SFSP**		

Section 1. Youth Information

4. Primary Diagnosis. List the name and the ICD-10 code of the youth's primary diagnosis necessitating the services being requested.

Section 1. Youth Information		
Youth Name:	Date of Birth:	RIN:
Primary Diagnosis:		ICD-10 Code:
Program Enrollment (check all that apply): ☐ **Pathways**	☐ **FSP**	☐ **SFSP**

Please put the text name AND the ICD-10 CODE of the youth's primary diagnosis.

Section 1. Youth Information

5. Program Enrollment. Check all applicable boxes to indicate the youth's program enrollment.

Section 1. Youth Information		
Youth Name:	Date of Birth:	RIN:
Primary Diagnosis:		ICD-10 Code:
Program Enrollment (check all that apply): ☐ **Pathways** ☐ **FSP** ☐ **SFSP**		

Section 2. CCSO Information

1. Provider Name. Enter the name of the CCSO organization making the request.
2. NPI. Enter the 10-digit NPI number associated with the CCSO making the request. This must be the NPI associated with the CCSO's IMPACT provider enrollment that will be used to submit claims for ISS and TSS.
3. HFS Provider Number. Enter the 12-digit HFS provider ID for the CCSO making the request. This must be the provider ID associated with the CCSO's IMPACT provider enrollment that will be used to submit claims for ISS and TSS.

Section 2. CCSO Information		
Provider Name:	NPI:	HFS Provider Number:
Requestor Name:	Phone:	Email:

Section 2. CCSO Information

1. Requestor Name. Enter the name of the person submitting the request. This is who HFS or its designee will contact with any questions about the request.
2. Phone. Enter a contact phone number for the person submitting the request.
3. Email. Enter a contact email for the person submitting the request.

Section 2. CCSO Information		
Provider Name:	NPI:	HFS Provider Number:
Requestor Name:	Phone:	Email:

Section 3. Requested Service Detail

1. Request type. Check the appropriate box to indicate if this is an initial request or an update to an already approved ISS/TSS request.
2. Requested service. This section is only required for initial requests. Check the appropriate box to indicate if the request is for TSS or ISS.

Section 3: Requested Service Detail	**Request type:** ☐ Initial ☐ Update to an approved request
Requested Service (complete this section for all initial requests)	
☐ **Therapeutic Support Services (H0046)** **Modality of therapy requested:** ☐ Equine ☐ Art ☐ Music ☐ Dance/Movement ☐ Drama ☐ Horticultural	
☐ **Individual Support Services (T1999). Check the specific service category requested below:** **Physical wellness** **Special or therapeutic youth development programming** **Strengths-developing activities** **Sensory items** **Parent education/training.**	

Section 3. Requested Service Detail

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Section 3: Requested Service Detail **Request type:** ☐ Initial ☐ Update to an approved request

Requested Service (complete this section for all initial requests)

☐ **Therapeutic Support Services (H0046)**

Modality of therapy requested: ☐ Equine ☐ Art ☐ Music ☐ Dance/Movement ☐ Drama ☐ Horticultural

☐ **Individual Support Services (T1999). Check the specific service category requested below:**

- Physical wellness
- Special or therapeutic youth development programming
- Strengths-developing activities
- Sensory items
- Parent education/training.

Section 3. Requested Service Detail

CCSO Handbook: 211.4.4 Therapeutic Support Services HCPCS: H0046 – Page 58

Staff Qualifications: TSS interventions may only be provided by an individual qualified in the specific intervention being delivered, consistent with the table below.

Intervention	Staff Qualifications
Art Therapy	Credentialed by the Art Therapy Credentials Board
Dance/Movement Therapy	Credentialed or board certified by the American Dance Therapy Association
Equine-Assisted Therapy	Certification or credential in equine-assisted therapy from a recognized national or international non-profit association
Horticultural Therapy	Professional registration with the American Horticultural Therapy Association
Music Therapy	Certified by the Certification Board for Music Therapists
Drama Therapy	Credentialed by the North American Drama Therapy Association

☐ **Therapeutic Support Services (H0046)**

Modality of therapy requested: ☐ Equine ☐ Art ☐ Music ☐ Dance/Movement ☐ Drama ☐ Horticultural

Section 3. Requested Service Detail

CCSO Handbook: 211.4.3 Individual Support Services HCPCS: T1999 – Page 57

- Physical wellness activities and goods that promote a healthy lifestyle through physical activity (i.e., sports club fees or gym memberships; bicycles, scooters, roller skates and related safety equipment) and nutrition education (i.e., cooking classes, non-credit nutrition courses);
- Special or therapeutic youth development programs offered by a community-based organization that serve individuals with disabilities who otherwise would not be able to successfully participate in traditional youth development programs. These programs focus on developing social skills through youth development opportunities that are supported by staff with specialized training;

Individual Support Services (T1999). Check the specific service category requested below:

- ☐ **Physical wellness**
- ☐ **Special or therapeutic youth development programming**
- ☐ **Strengths-developing activities**
- ☐ **Sensory items**
- ☐ **Parent education/training.**

Please describe/name the specific ISS activity, service, or good being requested:

Section 3. Requested Service Detail

CCSO Handbook: 211.4.3 Individual Support Services HCPCS: T1999 – Page 57

- Physical wellness activities and goods that promote a healthy lifestyle through physical activity (i.e., sports club fees or gym memberships; bicycles, scooters, roller skates and related safety equipment) and nutrition education (i.e., cooking classes, non-credit nutrition courses);
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- ☐ **Special or therapeutic youth development programming**
- ☐ **Strengths-developing activities**
- ☐ **Sensory items**
- ☐ **Parent education/training.**

Please describe/name the specific ISS activity, service, or good being requested:

Section 3. Requested Service Detail

CCSO Handbook 211.4.3 Individual Support Services HCPCS: T1999 Cont.

- Strengths-developing activities (i.e., music lessons, art lessons, therapeutic summer camp);
- Sensory items *ordered* by a licensed occupational therapist, speech-language pathologist, physical therapist, or LPHA; and
- Parent education and training.

Individual Support Services (T1999). Check the specific service category requested below:

- ☐ **Physical wellness**
- ☐ **Special or therapeutic youth development programming**
- ☐ **Strengths-developing activities**
- ☐ **Sensory items**
- ☐ **Parent education/training.**

Please describe/name the specific ISS activity, service, or good being requested:

Section 3. Requested Service Detail

CCSO Handbook 211.4.3 Individual Support Services HCPCS: T1999 Cont.

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CCSO Handbook 211.4.3 Individual Support Services HCPCS: T1999 Cont.

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- ☐ **Sensory items**
- ☐ **Parent education/training.**

Please describe/name the specific ISS activity, service, or good being requested:

Section 3. Requested Service Detail

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- ☐ Strengths-developing activities
- ☐ Sensory items
- ☐ Parent education/training.

Please describe/name the specific ISS activity, service, or good being requested:

Documenting Medical Necessity in the IM+CANS (IPOC)

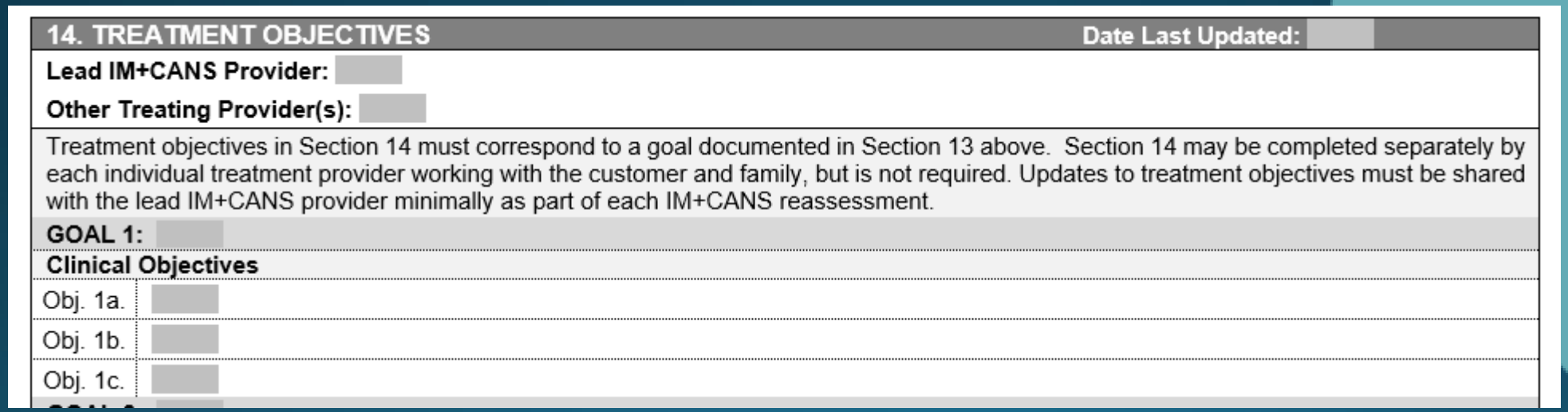
The IM+ CANS establishes Medical Necessity when the submitted IM+CANS Treatment Plan clearly documents how the requested items or activities are linked to one or more goals/objectives (IM+CANS section 16) AND the requested service is listed in Section 17: Aligning Supports: Services/Interventions.

- Section 14 – Individual Plan of Care • Created a new section 14, Treatment Objectives. • Added space to document the lead IM+CANS provider and other treating provider(s). • Added a Progress text box to document progress toward treatment objectives.
- Section 15 – Recommended Behavioral Health Services/Interventions • Changed Objective(s) column to Goal(s), tying the service need to the goal rather than specific objectives. • Renamed Service Type as Service Name • Removed columns for Mode and Place of Service. • Changed Agency and Staff Responsible column to Rendering Provider, with instruction to list only 1 agency or individual practitioner per row.

- IATP | HFS (illinois.gov)

Documenting Medical Necessity in the IM+CANS (IPOC)

- Section 14 – Individual Plan of Care • Treatment Objectives. • Added space to document the lead IM+CANS provider and other treating provider(s). https://hfs.illinois.gov/medicalproviders/behavioral/communitymentalhealthcenter/iatp.html



14. TREATMENT OBJECTIVES	Date Last Updated:
Lead IM+CANS Provider:	
Other Treating Provider(s):	
Treatment objectives in Section 14 must correspond to a goal documented in Section 13 above. Section 14 may be completed separately by each individual treatment provider working with the customer and family, but is not required. Updates to treatment objectives must be shared with the lead IM+CANS provider minimally as part of each IM+CANS reassessment.	
GOAL 1:	
Clinical Objectives	
Obj. 1a.	
Obj. 1b.	
Obj. 1c.	

Documenting Medical Necessity in the IM+CANS (IPOC)

- Section 15 – Recommended Behavioral Health Services/ Interventions • Tied to a goal. • List only one agency or individual rendering practitioner per row.
  https://hfs.illinois.gov/medicalproviders/behavioral/communitymentalhealthcenter/iatp.html
- Section '211.4 Covered Services' begins on page 56 of the CCSO handbook. This section details a complete listing of the services for which CCSOs may receive payment.
  - 211.4.3 Individual Support Services: Page 57

15. RECOMMENDED BEHAVIORAL HEALTH SERVICES/INTERVENTIONS

Section 15 must include all services the LPHA listed below is authorizing within their scope of practice, regardless of funding source. Other recommended services should be documented in sections 16-18, regardless of funding source.

Goal(s)	Service Name (see IM+CANS Appendix A for key)	Amount (how much?)	Frequency (how often?)	Duration (how long?)	Rendering Provider (list only 1 agency or individual practitioner)

Documenting Medical Necessity in the IM+CANS (IPOC)

14. TREATMENT OBJECTIVES — **Date Last Updated:**

Lead IM+CANS Provider:

Other Treating Provider(s):

Treatment objectives in Section 14 must correspond to a goal documented in Section 13 above. Section 14 may be completed separately by each individual treatment provider working with the customer and family, but is not required. Updates to treatment objectives must be shared with the lead IM+CANS provider minimally as part of each IM+CANS reassessment.

GOAL 1:

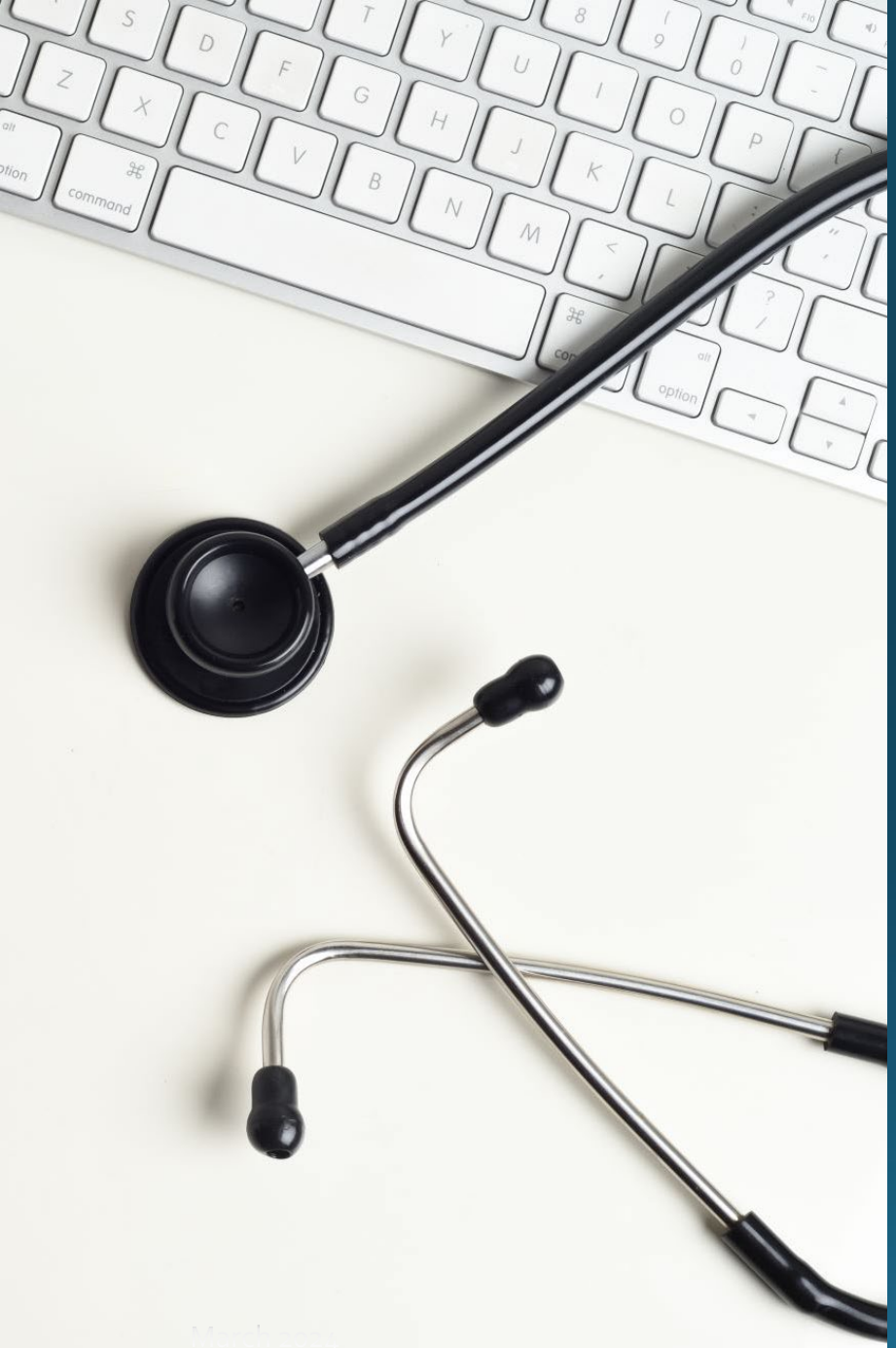
Clinical Objectives

Obj. 1a.	
Obj. 1b.	
Obj. 1c.	

15. RECOMMENDED BEHAVIORAL HEALTH SERVICES/INTERVENTIONS

Section 15 must include all services the LPHA listed below is authorizing within their scope of practice, regardless of funding source. Other recommended services should be documented in sections 16-18, regardless of funding source.

Goal(s)	Service Name (see IM+CANS Appendix A for key)	Amount (how much?)	Frequency (how often?)	Duration (how long?)	Rendering Provider (list only 1 agency or individual practitioner)



The 'Ordering' of Sensory Items

Licensed Practitioners establish the medical necessity for an item and may 'order' the required item. 'Order' in this case means a Medical Order.

- The service itself is documented on the treatment plan of the IM+CANS, which should then link the service back to one of the Individual Plan of Care treatment Objectives in Section 14
- If the sensory item is ordered by a provider other than the LPHA, this will be documented in Section 17, 'Additional Assessment/Functioning Evaluations Recommended by LPHA.' Identify the provider (name and credentials) ordering the sensory item. Additionally, the CCSO should obtain a copy of the order from the LPHA and maintain the copy in the client's clinical record.

Section 3. Requested Service Detail cont.

- Rendering/supplying individual or organization. Enter the name of the individual or organization that will be delivering the requested service or from which the requested item will be purchased. This should match the documentation provided to verify the service cost.

Rendering/Supplying Individual or Organization:					
Requested Date(s) of Service:	Start Date: __			End Date: __	
Requested Service Amount:		x	$	=	$
	# of Units		Per unit Cost		Total Cost

Section 3. Requested Service Detail cont.

- Requested date(s) of service. Enter the start and end date on the services being requested will be rendered or purchased. If only a single date is being requested, please enter the same date in both the start and end date boxes. Please note:
  - The requested dates must fall within the youth's Pathways eligibility period.
  - If the requested dates span a new fiscal year (over June 30th to July 1st), the request must be split into two separate requests.
  - Requests must not be submitted with a start date more than 90 days from the date the request was submitted. There is an exception for therapeutic summer camp requests.
  - Requests must not be in excess of a 90-day duration.

Rendering/Supplying Individual or Organization:					
Requested Date(s) of Service:	Start Date: __			End Date: __	
Requested Service Amount:		x	$	=	$
	# of Units		Per unit Cost		Total Cost

Section 3. Requested Service Detail cont.

Requested service amount. The number of units and per unit cost noted here must match how the provider submits claims for reimbursement.

- Currently, the HFS claims system can only accept one claim per each approved ISS/TSS prior authorization request. Providers requesting multiple units of the same service across a date span must either:
  1. wait until all units of service have been provided to the youth and bill all units on a single claim; or,
  2. break up the request into multiple prior authorization requests to allow for more frequent billing.

Requested Service Amount:		**X**	**$**	**=**	**$**
	# of Units		Per unit Cost		Total Cost

Section 3. Requested Service Detail cont.

- # of units. Enter the number of units requested.
- Per unit cost. Enter the cost for each unit.
- Total cost. Enter the total cost for this request (number of units multiplied by the per unit cost).

Rendering/Supplying Individual or Organization:						
Requested Date(s) of Service:	Start Date: __				End Date: __	
Requested Service Amount:		x	$	=	$	
	# of Units		Per unit Cost		Total Cost	

Section 3. Requested Service Detail cont.

- # of units. Enter the number of units requested.
- Per unit cost. Enter the cost for each unit.
- Total cost. Enter the total cost for this request (number of units multiplied by the per unit cost).

Rendering/Supplying Individual or Organization:						
Requested Date(s) of Service:	Start Date: __				End Date: __	
Requested Service Amount:		x	$	=	$	
	# of Units		Per unit Cost		Total Cost	

Section 3. Requested Service Detail cont.

- # of units. Enter the number of units requested.
- Per unit cost. Enter the cost for each unit.
- Total cost. Enter the total cost for this request (number of units multiplied by the per unit cost).

Rendering/Supplying Individual or Organization:					
Requested Date(s) of Service:	Start Date: __			End Date: __	
Requested Service Amount:		x	$	=	$
	# of Units		Per unit Cost		Total Cost

Section 3. Requested Service Detail cont.

Requested updates. Only complete this section if requesting an update to an approved request for any reason. Providers **must** also submit an update to request the prior authorization if the youth does not utilize the approved services in full for any reason (e.g. 10 sessions were approved but the youth only attended 8).

1. HFS issued prior authorization number. Enter the HFS prior authorization number issued for the approved ISS/TSS services for which a change is being requested.
2. Provide a brief description of what you are requesting be changed and why. Appropriate documentation must be submitted, as applicable, to support the change request.

Requested Updates (only complete this section for updates to an approved request)
HFS issued prior authorization number: _ **Please describe what you are requesting be updated and a brief explanation of why. Please attach any additional documentation in support of this request (e.g., proof of change to cost).**

Section 4: Required Attachments

- A copy of the youth's current IM+CANS must be submitted with all ISS/TSS prior authorization requests.
  - The IM+CANS must clearly document the requested service as a recommended service and be clearly linked to a goal on the treatment plan.
- Verification of the cost of service being requested must be submitted with all ISS/TSS prior authorization requests.
- For TSS service requests, verification of the credentials of the individual qualified in the specific TSS intervention being delivered must be submitted.

Please submit completed requests to:
HFS.BHPriorAuth@Illinois.gov

Policy Questions may be directed to:
HFS.FSP@Illinois.gov