Office of Medicaid Innovation

University of Illinois System

Altogether Extraordinary™

Prior Authorization Request Form
Individual and Therapeutic Support Services

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

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.
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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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- ☐ **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.

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

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

Section 3. Requested Service Detail

- Please describe/name the specific ISS activity or good being requested.

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- ☐ 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:

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 16: Treatment Goals and Objectives
- Section 17: Aligning Supports: Services/Intervention.

Documenting Medical Necessity in the IM+CANS (IPOC)

- Section 16: Treatment Goals and Objectives: Treatment goals and objectives should be stated in client/family language and should related back to the CANS actionable items.
  - Goals are specific, observable outcomes related to functioning that result from targeting symptoms and behaviors.
  - Objectives are specific steps to reach the goal.

Documenting Medical Necessity in the IM+CANS (IPOC)

- Section 17: Section 17: Aligning Supports: Services/Intervention.
- The requested service must be documented as a recommended service/Intervention.
  - Section '211.4 Covered Services' begins on page 56 of the CCSO handbook. Detailed in this section is a full listing of the services for which CCSOs may receive payment.
    - 211.4.3 Individual Support Services: Page 57
    - 211.4.4 Therapeutic Support Services: Page 58

Documenting Medical Necessity in the IM+CANS (IPOC)

IM+CANS Box 17: Aligning Supports

Use the service key and mode key below to complete the service section of the treatment plan. For services not listed, please indicate "Other" in the Service Type line, and specify the services/interventions to be pursued.

SERVICE TYPE	KEY	SERVICE TYPE	KEY	SERVICE TYPE	KEY	SERVICE TYPE	KEY
Therapy/Counseling	TC	Assertive Comm. Treatment	ACT	Case Mgmt – Transition Linkage, Aftercare	TLA	Psych Med Administration	PMA
Community Support	CS	Case Mgmt – Mental Health	MH	Mental Health Intensive Outpatient	IO	Psych Med Monitoring	PMM
Community Support Team	CST	Case Mgmt – Client Centered Consultation	CCC	Psychosocial Rehabilitation	PSR	Psych Med Training	PMT

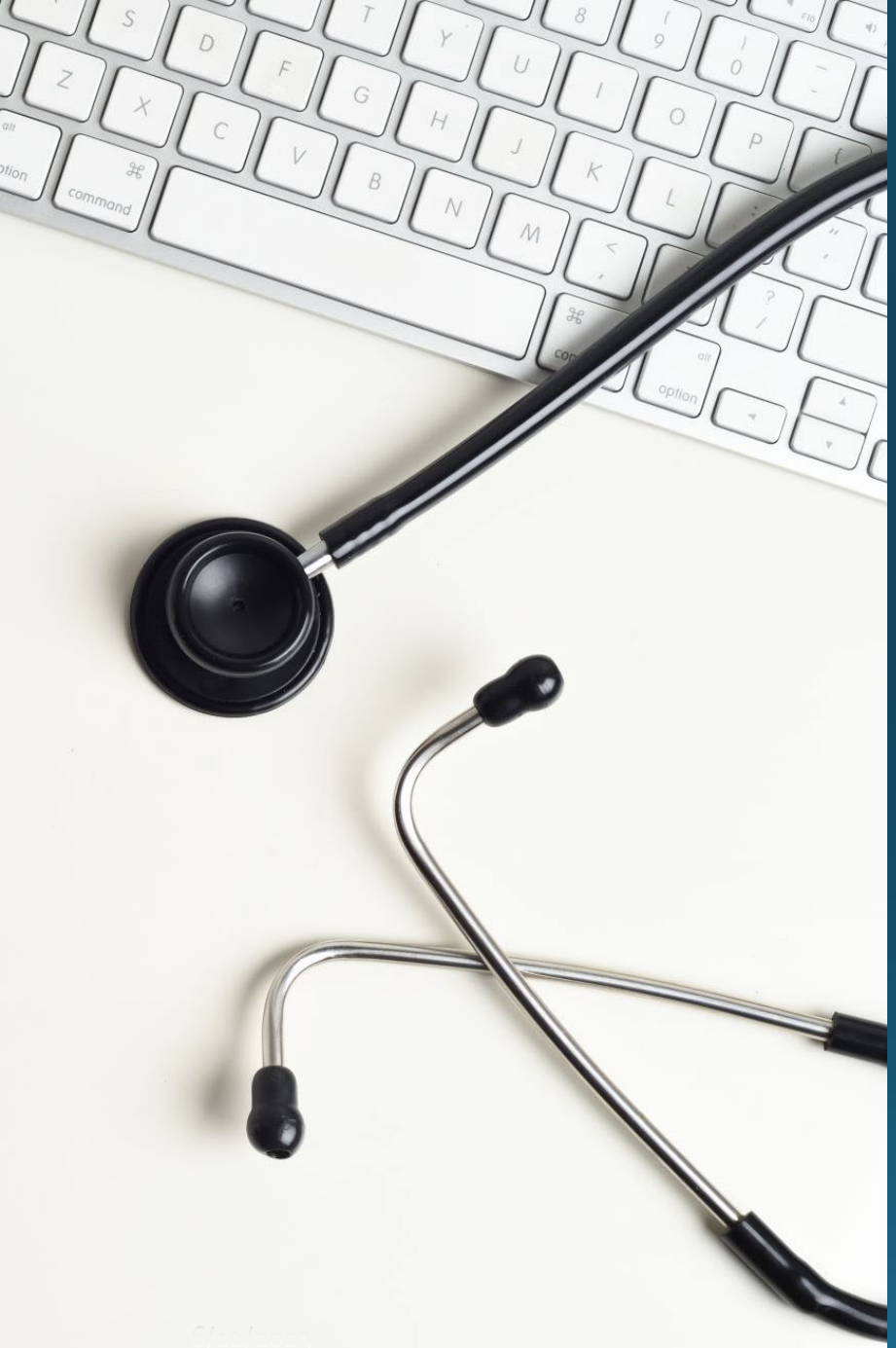
SERVICE MODE KEY				PLACE OF SERVICE KEY	
Individual = I	Group = G	Family = F	Residential = R	On-Site = ON	Off-Site = OFF

17. SERVICES/INTERVENTIONS

Objective(s)	Service Type	Mode	Place of Service	Amount	Frequency	Duration	Agency and Staff Responsible
2C	TC	I	ON & OFF	1 hour	Weekly	3 months	Brian Roberts, LPHA
1B, 1C	PMM	I	ON	30 minutes	Daily	3 months	Melissa Wright, MD Drew Goode, MHP
1C, 2A, 2B, 2C, 3A, 3B	CS	I	OFF	3 hours	Weekly	3 months	Drew Goode, MHP
1A, 1B, 2C, 3B, 3C	MH	I	ON & OFF	2 hours	Weekly	3 months	Drew Goode, MHP
1A, 1B, 2C, 3B, 3C	CCC	I	ON	1 hour	Weekly	3 months	Brian Roberts, LPHA

Documenting Medical Necessity in the IM+CANS (IPOC)

A01000	**Serv Needs**	Service/Needs 1: Anger Control/Frustration Tolerance; Priority - High		
G01100	**Goal**	Client goal and expectation: "I will learn to control my anger and self regulate".		
O01110	**Objective**	I will implement the coping skills which I find most effective, when necessary.		
O01120	**Objective**	I will participate during my sessions with the behavior support specialist.		
O01130	**Objective**	I will engage in Equine Therapy to improve my impulse control, raise emotional awareness, and improve my problem solving skills.		
T011Z1	**intervention**	Community Support - Individual	2 hrs every other week for 26 weeks	[redacted] yn
T011Z2	**Intervention**	Therapeutic Support Services	1 hr every other week for 26 weeks	Barbara O'Neil - HorsePower therapeutic riding
T011Z3	**Intervention**	Psychotropic Medication Monitoring	1 hour per month for 6 months	[redacted]
T011Z4	**Intervention**	Care Coordination and Support	2-4 hrs per week for 26 weeks	



The 'Ordering' of Sensory Items

Licensed Practitioners establish the medical necessity for an item and as such 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 treatment plan's goals (Section 16 of the IM+CANS).
- In Section 13 of the IM+CANS, "Additional Client Functioning Evaluations Recommended by LPHA," it is recommended indicating who (name and credentials) is ordering the sensory item.
- If it is the same LPHA that is signing off to authorize the IM+CANS, no other documentation should be needed.
- If a different LPHA is ordering the item, 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