



Department of Medical Assistance Services  
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[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

# MEDICAID MEMO

**TO:** All Treatment Foster Care Case Management and Residential Treatment Service Providers and Managed Care Organizations Participating in the Virginia Medical Assistance Programs

**FROM:** Patrick W. Finnerty, Director  
Department of Medical Assistance Services

**DATE:** 08/21/2006

**SUBJECT:** Updates and Clarification of the Prior Authorization Process for Treatment Foster Care Case Management and Residential Treatment Services

The purpose of this memorandum is to provide updates and clarification for the prior authorization (PA) process with Virginia Medicaid's PA contractor, Keystone Peer Review Organization (KePRO). This memorandum summarizes PA-related information previously communicated in several Medicaid Memoranda beginning March 20, 2006. We understand that some providers have experienced delays and issues with the process and hope that these general guidelines will assist with the transition. We ask for your patience and understanding during this transition as we improve the timeliness of this process.

The implementation of the new PA process was completed on June 19, 2006. KePRO handles PA review for all services except the following: (1) those services maintained with existing vendors (Pharmacy, Dental, Transportation, Mental Retardation & Day Support Waivers, and Managed Care Organizations); (2) those authorizations maintained by DMAS Medical Support (Organ Transplants, Gastric Bypass, Cosmetic Procedures, Prostheses); and, (3) certain waiver enrollment/service authorizations maintained by DMAS Long-Term Care.

## **1. iEXCHANGE Updates**

Providers can use iEXCHANGE, the KePRO web-based PA system, to submit PA requests 24 hours a day, seven days a week via the Internet. Registration is required and once completed, providers can expect to receive their iEXCHANGE user login and password by email within 10 business days. A step-by-step iEXCHANGE user manual, an on-line pre-recorded training presentation with iEXCHANGE demo, and other helpful resources are available on the KePRO website at: <http://dmas.kepro.org/default.aspx?page=iexchange>. If you have questions or concerns about

iEXCHANGE, please contact KePRO at (888) 827-2884, (804) 622-8900, or [ProviderIssues@kepro.org](mailto:ProviderIssues@kepro.org).

## **2. Verify Client Eligibility**

Providers are encouraged to verify the client's eligibility and enrollment prior to submitting PA requests to KePRO. Because many Medicaid, FAMIS Plus, and FAMIS individuals are enrolled with a DMAS Managed Care Organization (MCO), eligibility verification avoids unnecessary delays associated with PA submissions to an incorrect payer source. Recipients who receive DMAS authorized Treatment Foster Care Case Management (TFC-CM) or Residential Treatment Care (RTC) are not eligible to participate in the DMAS MCO programs. DMAS will disenroll recipients from the MCO upon notification of the recipient's authorized entry into either of these programs.

DMAS offers a web-based Internet option (ARS) for eligibility verification purposes. The website address to use to enroll or access this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

## **3. Efficiency of PA Request Submissions**

PA requests may be submitted by fax, mail, or iEXCHANGE. Updated PA fax request forms and instructions for these services are attached to this memo and are posted on the KePRO website at <http://dmas.kepro.org/> and the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov). The forms have been updated based upon provider feedback, and are available in two formats: (1) a PDF version that providers can download and complete manually; and, (2) an editable Word version, that allows providers to save the form and input responses directly. (Use of editable version of the PA request form will expedite processing.)

When submitting by fax and/or mail, providers must use the updated PA request form, including all relevant clinical information in the required fields. Additionally, certain documents are required to be attached to the forms, as noted in the PA request form instructions. Please do not send attachments except as noted in the PA request form instructions. *Starting September 1, 2006 KePRO will reject requests that are submitted with old forms and unauthorized attachments.*

Providers also have the option of submitting PA requests through iEXCHANGE and following up by fax with any required attachments (as noted in the PA request form instructions). To ensure that faxed documentation for an open case (i.e., submitted through iEXCHANGE) can be easily identified from an initial PA request fax, the faxed attachments must include the assigned case number (*described in more detail below*). **One advantage of submitting the PA request through iEXCHANGE versus fax/mail is that the provider can follow-up by iEXCHANGE to communicate with KePRO electronically regarding any details of the case and to verify PA status.**

Once your request has been submitted either by fax/mail or iEXCHANGE, a case ID number is generated. The case ID number is used to track this specific case through KePRO's system. Please note that this is not your PA number. The PA number will also be posted on iEXCHANGE (and sent via fax for telephone and fax PA submissions). Providers may also check prior authorization status through MediCall (1-800-884-9730 or 1-800-772-9996) or the DMAS web-based automatic response system (ARS) at <http://virginia.fhsc.com>.

Clients and providers will continue to receive written notifications of service approvals, partial approvals, and denials. These PA notification letters are sent to the provider address on file, as indicated by the provider in their enrollment filing with DMAS. Written letters will also identify applicable provider and client appeal rights and instructions.

KePRO is unable to alter any information submitted on PA requests. Providers are responsible for providing accurate and correct information on their PA requests. If additional information is required, KePRO will notify the provider through iEXCHANGE (or via fax for telephone and fax PA submissions) of missing information. When responding back to KePRO providers should only submit the specific information requested.

#### **4. Special Instructions for Procedure and ICD-9 Diagnosis Codes**

**ICD-9 Diagnosis Codes** – The primary ICD-9 diagnosis code relative to the PA requested service(s) is **required on all PA submissions**. This is the code that is required on the claim sent to DMAS. A complete DSM-IV diagnosis is also required for the review process for both Treatment Foster Care Case Management and Residential Treatment. *iEXCHANGE provides a search feature for ICD-9 codes. These codes are also available in an Excel format on the KePRO website at:*  
<http://dmas.kepro.org/default.aspx?page=faq>.

#### **5. PA Timely Filing Requirements**

DMAS has extended the relaxed requirement of timely submission for PA requests through September 30, 2006. This applies for request dates beginning May 2006 (at the time of the KePRO implementation). Starting October 1<sup>st</sup>, timely submission for requests will again be applied and determinations will be made based on timeliness.

#### **6. Transportation through LogistiCare for Services Requiring PA**

The authorization “*issued for the medical service*” that is required for payment of any necessary transportation services through LogistiCare (DMAS’ Non-Emergency Transportation Contractor) has also been relaxed for all services requiring PA through August 31, 2006. Starting September 1, 2006, LogistiCare will resume application of any PA-related transportation rules.

### **TRAINING AND PA RESOURCE INFORMATION**

A pre-recorded Web-Ex training that provides an in-depth PA overview and an iEXCHANGE demo is available on the KePRO website at: <http://dmas.kepro.org/default.aspx?page=iexchange>. Providers may view this web-cast training at their convenience.

The most up-to-date PA information is posted on the DMAS Website at: [http://www.dmas.virginia.gov/pr-prior\\_authorization.htm](http://www.dmas.virginia.gov/pr-prior_authorization.htm) and the KePRO website at: <http://dmas.kepro.org>. Should you have any questions regarding the prior authorization process, please send your inquiries via e-mail to [providerissues@kepro.org](mailto:providerissues@kepro.org) or [PAUR06@dmas.virginia.gov](mailto:PAUR06@dmas.virginia.gov).

## **KePRO CONTACT INFORMATION**

You may contact KePRO through the following methods:

**iEXCHANGE:** <http://dmas.kepro.org/>

**Toll Free Phone:** 1-888-VAPAUTH (1-888-827-2884)

**Local Phone:** (804) 622-8900

**Fax:** 1-877-OKBYFAX (1-877-652-9329)

**Mail:** 2810 N. Parham Road, Suite 305, Richmond, VA 23294

**Other Provider Issues:** [ProviderIssues@kepro.org](mailto:ProviderIssues@kepro.org)

Some providers have experienced difficulty accessing KePRO's toll free telephone and fax numbers. It is our understanding that many providers have successfully resolved this issue by reporting the inability to access the KePRO numbers to their respective telephone vendor. Providers who are unable to access the KePRO fax number may submit through iEXCHANGE or telephone to: 804-622-8900, or by mail.

## **PRIOR AUTHORIZATION, ELIGIBILITY, AND CLAIMS STATUS INFORMATION**

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access prior authorization information including status via iEXCHANGE at <http://dmas.kepro.org/>.

## **COPIES OF MANUALS**

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov). Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

## **PROVIDER E-NEWSLETTER SIGN-UP**

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at: [www.dmas.virginia.gov/pr-provider\\_newletter.asp](http://www.dmas.virginia.gov/pr-provider_newletter.asp).

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Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.



<b>19) Non-CSA RTC Initial Reviews <u>Only</u>:</b>  <input type="checkbox"/> <b>Recipient was unsuccessful at less restrictive level of care.</b> Describe services currently receiving and why residential level of care is required. Is there a medical condition exacerbating the psychiatric problems?  <input type="checkbox"/> <b>Recipient's identified condition is escalating.</b> Provide specifics and describe why a physician must direct treatment. Also explain how services can reasonably be expected to improve the recipient's condition so that services will no longer be needed.  <input type="checkbox"/> <b>This is a reoccurrence of an acute psychiatric condition.</b> When was the most recent acute episode and describe condition treated?		<b>20) Non-CSA Reviews <u>Only</u>:</b>  <b>Education Payment Source</b>  <input type="checkbox"/> Scholarship (no charge)  <input type="checkbox"/> Adoption Subsidy Case  <input type="checkbox"/> Parents  <input type="checkbox"/> Other:			
<b>21) Day/Overnight passes</b>	<b>Date</b>	<b>Overnight (x)</b>	<b>Day (x)</b>	<b>With whom:</b>	<b>Successful (Y/N)</b>
	/ /				
	/ /				
	/ /				
	/ /				
<b>22) Required Attachments:</b>					
<b>RTC-CSA</b>		<b>RTC-Non-CSA</b>		<b>RTC-Non-CSA</b>	
<b><u>Initial Review</u></b>		<b><u>Initial Review</u></b>		<b><u>Continued Stay Review</u></b>	
1) CON (Certificate of Need) 2) IPOC (Initial Plan of Care) 3) Reimbursement Rate Certification  <u>Continued Stay Review</u> 1) 30-Day Progress Update 2) CIPOC (Comp. Ind. Plan of Care) 3) Reimbursement Rate Certification		1) Pre-Admission Screening Report (DMH224) or CON 2) IPOC (Initial Plan of Care)		1) Comp. Ind. Plan of Care *Required for 1 <sup>st</sup> Cont. Stay Only 2) 30-Day Progress Update *Most recent	

## **RESIDENTIAL TREATMENT CARE ELECTRONIC FAX FORM INSTRUCTIONS**

This FAX submission form is required for Residential Treatment Care (RTC) prior authorization review.

Please be certain that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via FAX for additional information.

If KePRO determines that your request meets appropriate review guidelines the request will be “tentatively approved” and transmitted to First Health Services (FHS) for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iEXCHANGE (<http://dmas.kepro.org>) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS’ Fiscal Agent prior to 5:30 PM of that day.

**1. Service type:**

- Place a  or **X** in the appropriate box.

**2. Request type:**

- Place a  or **X** in the appropriate box.
- **Initial Review:** Use for all new requests, unless the recipient has been in care for more than 30 days, then check continues stay review.
- **Continued Stay Review:** Use for concurrent reviews and for new clients who have been in care for over 30 days.

**3. Start Date requested:**

- The date you are want the requested service to begin.

**4. Expected Discharge (D/C) Date and Discharge plan:**

- Enter the expected discharge date on the line provided.
- Enter the current discharge plan on the line provided (i.e. foster home, group home, return home, etc.)

**5. Enrollee Last Name:**

- Enter the enrollee’s last name exactly as it appears on the Medicaid card.

**6. Enrollee First Name:**

- Enter the enrollee’s first name exactly as it appears on the Medicaid card.

**7. Enrollee Medicaid ID Number:**

- It is the provider’s responsibility to ensure the enrollee’s Medicaid number is valid. This field is limited to 12 numbers.

**8. Date of Birth:**

- Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).

**9. Sex:**

- Please place a  or **X** in the box to indicate the sex of the patient.

**10. Requesting/Service Provider:**

- Enter the requesting/service provider name.

**11. Requesting/Service Provider Address:**

- Enter the requesting/service provider's business address.

**12. Provider ID Number:**

- Enter the Provider ID number. This field is limited to 9 numbers.

**13. Requesting/Service Provider Contact Person:**

- Enter the primary contact for the requesting/service provider.

**14. Requesting/Service Provider Phone Number:**

- Enter the phone number of the requesting/service provider.

**15. Requesting/Service Provider Fax Number:**

- Enter the fax number of the requesting/service provider.

**16. DSM-IV Diagnoses:**

- Enter the complete DSM-IV diagnoses (Must include Axis I diagnosis).
- Only required for RTC Initial review, unless there are changes to the diagnoses.

**17. CAFAS/PECFAS (CSA Only):**

- Place a  $\checkmark$  or X in the box to indicate the functional assessment scale utilized.
- Enter the date the CAFAS/PECFAS was completed.
- Enter each subscale item number in the box beside each subscale, these are not the overall scores for each category, but rather the numbers that delineate specific behavioral challenges under each category. (\*\*when entering item numbers for a PECFAS the Substance Abuse (S.A.) box should not be filled in).
- Type/Write the *Caregiver* type (Primary, Surrogate, Non-Custodial) in the box beside the caregiver item score.

**18. Alternative Placements tried or Explored in the Past Year:**

- Place a  $\checkmark$  or X in the box to indicate whether or not alternative placements were tried or explored.
- If previous placements were tried/explored, list placements, give dates of placement, and indicate whether or not placements were successful by placing a  $\checkmark$  or X in each corresponding box.
- If placements were unsuccessful, indicate the reason in the space provided.

**19. Non-CSA Admission Questions Initial Reviews Only:**

- Place a  $\checkmark$  or X in the box to indicate each criteria met.
  - i. Then answer the questions under each box.

**20. Education Payment Source:**

- Place a  $\checkmark$  or X in the box to indicate the education payment source (Non-CSA Reviews Only).

**21. Day and Overnight Passes:**

- Place a  $\checkmark$  or **X** in the box if the recipient used day or overnight passes.
- If passes were used, fill in the boxes to indicate the date of the passes, type of pass, who the pass was with, and whether or not the pass was successful.

**22. Required Attachments:**

- **Under each service type, the listed attachments are required at the time of submission.**

**RTC-CSA**

Initial Review

- 1) CON (Certificate of Need)
- 2) IPOC (Initial Plan of Care)

Continued Stay Review

- 1) 30-Day Progress Update
- 2) CIPOC (Comp. Ind. Plan of Care)

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**RTC-Non-CSA**

Initial Review

- 1) Pre-Admission Screening Report (DMH224) or CON
- 2) IPOC (Initial Plan of Care)

Continued Stay Review

- 1) Comp. Ind. Plan of Care  
\*Required for 1<sup>st</sup> Cont. Stay Only
- 2) 30-Day Progress Update  
\*Most recent

**KePRO Intensive In-Home and Treatment Foster Care-Case Management Preauthorization Request Form**

*FAX: 1-877-OKBYFAX (877-652-9329) / Phone: 1-888-827-2884*

\*\*\*Please utilize the instructions when completing this form.\*\*\*

<b>1)</b> <input type="checkbox"/> TFC-CM  <input type="checkbox"/> IIH	<b>2)</b> <input type="checkbox"/> Initial Review  <input type="checkbox"/> Continued Stay Review  <b>PA Number:</b>	<b>3) Start Date requested:</b> /    /  <b>Admission Date:</b> /    /  <b>Requesting retroactive authorization:</b> <input type="checkbox"/> Y <input type="checkbox"/> N	<b>4) Expected D/C Date:</b>  /    /    /  <b>Discharge plan:</b>						
<b>5) Enrollee Last Name:</b>		<b>6) Enrollee First Name:</b>		<b>7) Enrollee Medical ID # :</b>					
<b>8) DOB (mm/dd/yyyy):</b> /    /		<b>9) Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>10) Provider Name:</b>		<b>11) Provider Address:</b>			
<b>12) Provider ID #:</b>		<b>13) Contact Person:</b>		<b>14) Provider Phone:</b>		<b>15) Provider Fax:</b>			
<b>16) DSM IV:</b>  Axis I _____ Axis II _____ Axis III _____ Axis IV _____ Axis V (GAF) Current:                      Highest level in past year:		<b>17) (TFC-CM ONLY)</b> CAFAS <input type="checkbox"/> PECFAS <input type="checkbox"/>  <b>School:</b> _____ <b>Home:</b> _____ <b>Community:</b> _____ <b>Behavior Toward Others:</b> _____ <b>Moods/Emotions:</b> _____  <b>Self-harm:</b> _____ <b>Substance Abuse</b> _____ <b>Thinking:</b> _____ <b>Caregiver Material Needs:</b> _____ <b>Caregiver Fam/Soc Support:</b> _____		<b>Date:</b> /    /		Enter item numbers in box beside each subscale.			
								<b>18) Alternative placements tried or explored in the past year? (TFC-CM Initial Review Only)</b> <input type="checkbox"/> Y <input type="checkbox"/> N	
<b>If placement(s) not successful, please explain:</b>									

	<b>19) Medication</b>			
	Name of medication	Dosage	Frequency	Compliant

**20.) Frequency (IIH Only)** Requested Extension (in weeks)

**21) Case Management (TFC-CM Only)**  
 Progress report updated every 90 days after placement and every 90 days thereafter  
 Case Manager Narratives kept current within 30 days (TFC Only)

**22) Current Behaviors: Please provide a narrative of the behaviors exhibited by the client over the past 30 days that warrant the requested level of care. (Please identify frequency, intensity and duration of each behavior)**  
 \_\_\_\_\_

**23) Please list services to be provided during the first 45 days of treatment (TFC-Case Management Initial Reviews Only):**  
 \_\_\_\_\_

<b>24) Required Attachments:</b>			
TFC-CM Initial	TFC-CM Continued Stay	IIH Extension Request	
1) FAPT Assessment  2) Reimbursement Rate Certification  **If in placement for more than 45 days also include attachments listed under <b><u>TFC Continued Stay</u></b>	1) Comprehensive Treatment and Service Plan 2) 90-day Progress Report  3) Most current 30 day Progress Update  4) Reimbursement Rate Certification	1) Comprehensive Treatment Plan 2) Most current 30-day Progress Update	

## **TREATMENT FOSTER CARE--CASE MANAGEMENT AND INTENSIVE IN-HOME SERVICES ELECTRONIC FAX FORM INSTRUCTIONS**

This FAX submission form is required for TFC-CASE MANAGEMENT and IIH prior authorization review.

Please be certain that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via FAX for additional information.

If KePRO determines that your request meets appropriate review guidelines the request will be “tentatively approved” and transmitted to First Health Services (FHS) for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to providers registered on the web-based program iExchange (<http://dmas.kepro.org>) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS’ Fiscal Agent prior to 5:30 PM of that day.

**1. Service type:**

- Place a  $\sqrt$  or **X** in the appropriate box.
- Only one service can be selected per fax form.

**2. Request type:**

- Place a  $\sqrt$  or **X** in the appropriate box.
- **Initial Review:** Use for all new requests, unless the recipient has been in care for more than 30 days, then check continues stay review.
- **Continued Stay Review:** Use for concurrent reviews and for new clients who have been in care for over 30 days. All IIH (extension) submissions should be under Continued Stay Review.

**3. Start Date requested:**

- The date you are want the requested service to begin.

**4. Expected Discharge (D/C) Date and Discharge plan:**

- Enter the expected discharge date on the line provided.
- Enter the current discharge plan on the line provided (i.e. permanent foster care, return home, adoption, etc.).

**5. Enrollee Last Name:**

- Enter the enrollee’s last name exactly as it appears on the Medicaid card.

**6. Enrollee First Name:**

- Enter the enrollee’s first name exactly as it appears on the Medicaid card.

**7. Enrollee Medicaid ID Number:**

- It is the provider’s responsibility to ensure the enrollee’s Medicaid number is valid. This should contain 12 numbers.

**8. Date of Birth:**

- Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).

**9. Sex:**

- Please place a  $\checkmark$  or **X** to indicate the sex of the patient.

**10. Requesting/Service Provider:**

- Enter the requesting/service provider name.

**11. Requesting/Service Provider Address:**

- Enter the requesting/service provider's business address.

**12. Provider ID Number:**

- Enter the Provider ID number. This should contain 9 numbers.

**13. Requesting/Service Provider Contact Person:**

- Enter the primary contact for the requesting/service provider.

**14. Requesting/Service Provider Phone Number:**

- Enter the phone number of the requesting/service provider.

**15. Requesting/Service Provider Fax Number:**

- Enter the fax number of the requesting/service provider.

**16. DSM-IV Diagnoses:**

- Enter the DSM-IV diagnoses.
  - Axes I through V are required for TFC-CM
  - Axes I and II are required for IIH
- This is only required for Initial TFC-Case Management reviews, unless there is a change in diagnoses.

**17. CAFAS/PECFAS:**

- Not required for IIH.
- Place a  $\checkmark$  or **X** to indicate the functional assessment scale utilized.
- Enter the date the CAFAS/PECFAS was completed.
- Enter each subscale item number in the box beside each subscale, these are not the overall scores for each category, but rather the numbers that delineate specific behavioral challenges under each category. (\*\*when entering item numbers for a PECFAS the Substance Abuse (S.A.) box should not be filled in).
- Type/Write the *Caregiver* type (Primary, Surrogate, Non-Custodial) in the box beside the caregiver item score.

**18. Alternative Placements tried or Explored in the Past Year:**

- Not required for IIH.
- Place a  $\checkmark$  or **X** to indicate whether or not alternative placements were tried or explored.
- If so, list placements, give dates of placement, and indicate whether or not placements were successful by placing a  $\checkmark$  or **X** in each corresponding box.
- If placements were unsuccessful, indicate the reason in the space provided.

**19. Medications:**

- Enter the psychotropic medications that the recipient is currently prescribed.
- Also enter the dosage of the medication, frequency that the recipient takes the medication, and mark an (X) under “compliant” if the recipient is compliant with the medication regimen.

**20. Frequency of Services (IIH Only):**

- Enter the requested number of hours per week for the extension of service in the space provided.
- Enter the anticipated extension duration (in weeks) in the space provided.

**21. Case Management (TFC-Case Management Continued Stay Only):**

- Place a  or X in the box to indicate progress reports are updated every 90 days after placement.
- Place a  or X in the box to indicate Case Manger narratives are kept current within 30 days.

**22. Current Behaviors:**

- In the space provided, please enter a narrative of the behaviors exhibited over the past 30 days that warrant the requested level of care. Please identify the frequency, intensity, and duration of each behavior.

**23. The First 45 Days of Treatment (TFC-Case Management Initial Only):**

- List services to be provided during the first 45 days of treatment.

**24. Required Attachments:**

- Under each service type, the listed attachments are required at the time of submission.

**TFC-Case Management Initial Review**

- ✓ FAPT Assessment
- ✓ Reimbursement Rate Certification
- ✓ \*\*If in placement for more than 45 days also include attachments listed under TFC-Case Management Continued Stay

**TFC-Case Management Continued Stay Review**

- ✓ Comprehensive Treatment Plan
- ✓ 90-day (Quarterly) Progress Update
- ✓ Most current 30-day Progress Update
- ✓ Reimbursement Rate Certification

**IIH Extension Request**

- ✓ Comprehensive Treatment plan (ISP)
- ✓ Most current 30-day Progress Update