



Children's Mental Health Bureau Comprehensive School and Community Treatment

Prior Authorization for Reduction in Team Member Composition

The Children's Mental Health Bureau (CMHB) requires public school districts providing CSCT to request prior authorization (PA) if the number of monthly units will exceed the allowable monthly unit limit for that team size. The allowable monthly units are based on team size. Prior authorization is required when it is anticipated the team will exceed these limits:

- CSCT team of one staff provides over 450 units per month
- CSCT team of two staff provides over 900 units per month.

If a team size change occurs after the 15th of the month, the adjusted rate will not take effect until the following month.

Please remember that clinical supervisors can fill in for the therapist or in-training therapist (please refer to ARM 37.87.1803). Teams that cannot meet the ARM requirements are advised to consider unbundling until they can again meet the CSCT requirements

The form below needs to be completed in its entirety in order for prior-authorization request to be considered.

School District requesting prior authorization to reduce the number of behavioral aides.	
School District NPI	
Mental Health Center providing CSCT services	
Team Number	
Team PID	
Current number of Behavioral Aides	
Number of Behavioral Aides after reduction in staffing	
Month(s) prior authorization requested (mm/yyyy)	
Number of additional units requested	
Number of youth currently being served	
Number of anticipated referrals during this time period	
Reason for Prior Authorization Request*	Please attach a summary documenting the reason for the prior authorization request to include why the team needs to provide more than the monthly limit per team size and the plan for the month. Please include information such as number of anticipated crises, student acuity, and other information that will support your request. All requests will be reviewed by the CMHB Clinical Team.

Please complete other side.

Request submitted by:

Name _____ Title _____

Signature _____ Date _____

Submit your prior authorization request via email to the Children's Mental Health Bureau

Christine White

CSCT Medicaid Program Officer, DPHHS Children's Mental Health Bureau

ChWhite@mt.gov

Questions? Please call (406) 444-5916

Reason for Prior Authorization Request

(enter documentation below or include separate document with PA request.)