

**Behavioral Health Partnership –
Child Psychiatric
Level of Care Guidelines**

Final

11/28/05

Guidelines for Making Level of Care Decisions

These Level of Care guidelines are designed to assist care managers and providers in assessing a child's clinical presentation and determining the appropriate level of care. This document should be used as a guideline for facilitating access to the treatment setting and interventions based on a child's severity of illness and intensity of service need. In general, children should be placed in the least restrictive level of care that is warranted by the severity of presenting symptoms, degree of functional impairment and environmental circumstances. The level of treatment intervention should match the presentation that necessitated the intervention. The ASO will allow for multiple levels of care to be authorized concurrently for the purpose of treatment continuity and flexibility in service planning. In all cases, the ASO will give due consideration to family choice and the provider's expertise and will engage in a highly collaborative care decision-making process with providers and families.

These guidelines are governed by the definitions of "medical necessity", "medical appropriateness" and "EPSDT" (for children under twenty-one (21)) included at the end of this document. Costs may be factored into decision-making only when two alternative treatments are equally effective.

A. Application of the Criteria

The application of the severity of illness criteria may be influenced by a variety of factors related to the child's psychiatric condition and living environment. Aspects of a child's condition that might warrant consideration in making level of care decisions include the following:

- Co-morbid psychiatric conditions
- Co-morbid substance abuse conditions
- Co-morbid developmental disabilities
- Co-morbid biomedical conditions
- Persistence of symptoms
- Relapse potential
- Prevalence of risk behaviors and victimization issues

Environmental factors that may influence level of care decisions include:

- Residence (e.g., home, shelter, residential center)
- Family functioning
- Major life events
- Abuse/neglect
- Treatment motivation
- Educational functioning

Although admission and continued care decisions should not be made solely on the basis of environmentally based risk, these factors need to be considered in treatment planning. Environmentally based factors may provide the impetus for continuing

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services or for facilitating access to a higher or lower level of care. Strengths and protective factors should be considered in all care decision making.

When clinical presentation supports more than one level of care, the intensity of service need, prior treatment history and the presence of protective factors are used to determine the most appropriate level of care.

B. Mitigating Factors

Although efforts should always be made to review a child's course of treatment and level of care determination based on clinical and environmental factors listed above, there are particular events that might require a decision that falls out of the parameters listed above. Special consideration may be made for the following circumstances:

- Court ordered evaluation or treatment.
- The level of care that the child needs and is eligible for is currently not available and the child's safety and well being requires placement in an alternative level of care, irrespective of clinical need.
- There is limited availability of the identified community provider network and to discharge out of one level of care to a less restrictive level of care without these identified supports in place would place the child at risk for clinical deterioration.

C. Medicaid Definitions

1. Medical Necessity - Health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.
2. Medical Appropriateness - Health care that is provided in a timely manner and that meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.
3. EPSDT – Connecticut Medicaid recipients under the age of twenty one (21) are entitled to the benefits of the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program which includes an age-appropriate behavioral health and developmental assessment and any medically necessary follow-up treatment.

The HUSKY A MCOs are responsible for ensuring the provision of an assessment of a child's behavioral health. A child may be referred to either the MCO or the ASO for an inter-periodic screen by a professional who comes in contact with a child outside of the formal health care system. The ASO is responsible for ensuring the provision of an inter-periodic assessment of a child's behavioral health when a child is referred either directly to a behavioral health provider in the BHP network or to an ASO care manager.

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The ASO's care managers or other ASO staff must authorize all medically necessary behavioral health services that may be recommended or ordered pursuant to an EPSDT periodic or inter-periodic screening including medically necessary health care services that are not otherwise covered under the Connecticut Medicaid program. Care managers or other ASO staff are also required to facilitate access to such services when contacted by the recipient or the recipient's designated representative.

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A. ACUTE INPATIENT PSYCHIATRIC HOSPITALIZATION

Definition

Inpatient treatment services in a licensed general, psychiatric hospital or a state operated psychiatric hospital offering a full range of diagnostic, educational, and therapeutic services with capability for emergency implementation of life-saving medical and psychiatric interventions. Services are provided in a physically secured setting. Patient admission into this level of care is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. This service is generally used when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization, and intensive brief treatment.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. The first authorization is for up to 3 days. Subsequent authorizations are based on the individual needs of the patient with consideration of the physician's recommendations. Admissions to Riverview Hospital shall be reviewed for medical necessity and will require concurrent reviews on a periodic basis to facilitate discharge planning.

The first 30 days of Court ordered admissions to Riverview Hospital shall be deemed medically necessary and so authorized. Such stays shall be subject to clinical review 21 days post admission to assist with timely discharge planning. Any court ordered stay beyond 30-days shall require prior authorization and be authorized for up to seven days.

Level of Care Guidelines

A.1.0 Admission Criteria

A.1.1 Symptoms and functional impairment include all of the following:

A.1.1.1 Diagnosable DSM Axis I or Axis II disorder,

A.1.1.2 Symptoms and impairment must be the result of a psychiatric or substance abuse disorder, excluding V-codes,

A.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation, and GAF <30

A.1.2 Presentation consistent with at least one of the following Symptom Categories:

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- A.1.2.1 Current risk of suicide/self-injury: Imminent risk of suicide or self-injury, with an inability to guarantee safety in a less restrictive environment as manifested by:
- A.1.2.1.1 Attempt: Recent and serious suicide attempt indicated by degree of lethal intent, impulsiveness of actions and/or concurrent intoxication. Inability to reliably contract for safety; or
 - A.1.2.1.2 Intent/Plan: Current suicidal ideation with well formulated plan, imminent intent to act and available means that is severe and dangerous with minimal expressed ambivalence or significant barriers to doing so; or
 - A.1.2.1.3 Self-mutilation: Recent self-mutilation that is severe and dangerous, e.g., deep cuts requiring sutures, 2nd to 3rd degree burns, swallowing objects; or
 - A.1.2.1.4 Hallucinations and/or Delusions: Recent command/threatening hallucinations or delusions that threaten to override usual impulse control and likely to result in harm to self or others; or
 - A.1.2.1.5 Extreme recklessness/agitation/impulsivity: Repeated pattern of reckless behavior suggesting an inability or unwillingness to consider potential for risk to self (e.g. extreme scratching, inserting objects, driving while intoxicated, driving without a license, running into traffic; hanging from a moving car; jumping from high places, dangerous use of substances, provocation of others, flagrant exposure to victimization, and other potentially highly self injurious or lethal risk-taking behavior).
- A.1.2.2 Current risk of homicide/danger to others: Imminent risk of homicide or harm to others with inability to guarantee safety in a less restrictive environment as manifested by:
- A.1.2.2.1 Attempt: Recent and serious homicide attempt indicated by degree of lethal intent, impulsivity and/or concurrent intoxication, severe and dangerous, or inability to reliably contract for safety or a history of serious pat attempts that are not of a chronic, impulsive, or consistent nature; or
 - A.1.2.2.2 Intent/Plan: Current homicidal ideation with well formulated plan, imminent intent to act and available means that is severe and dangerous with

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minimal expressed ambivalence or significant barriers to doing so; or

A.1.2.2.3 Severe assault: Recent physically assaultive behavior with a high potential for recurrence and high potential for serious injury to self or others; or

A.1.2.2.4 Hallucinations and/or Delusions: Recent command/threatening hallucinations likely to result in harm to self or others; or

A.1.2.2.5 Extreme recklessness/ /impulsivity: Sustained reckless or impulsive behavior suggesting an inability or unwillingness to consider potential for serious risk to others (e.g. fire setting, sexual abuse, reckless driving, and other risk-taking behavior); or

A.1.2.2.6 Agitation/Aggression: Sustained agitated and uncontrolled behavior including acts of violence against property or persons with high risk of recurrence.

A.1.2.3 Gravely Disabled: Acute and serious deterioration from baseline in mental status and level of functioning resulting in high risk of harm to self or others. Severe impairment of activities of daily living skills and not secondary to abuse or neglect as evidenced by one or more of the following:

A.1.2.3.1 Evidence of severe neglect of personal hygiene (i.e. highly malodorous, parasitic infestation, poor/no oral hygiene, grossly soiled clothing, inability to manage toileting tasks appropriately) despite appropriate and repeated attempts by caretakers to alter behaviors; or

A.1.2.3.2 Malnutrition of life-threatening severity and/or highly compromised nutrition or eating patterns (i.e. eating only food packaged in cellophane, eating only peas counted out one by one) which may be related to paranoid, delusional, or severe eating-disordered beliefs or rituals; or

A.1.2.3.3 Immobility with potential to compromise physical status; or

A.1.2.3.4 Unable to communicate basic needs or

A.1.2.3.5 Catatonia; or

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- A.1.2.3.6 Severe psychomotor agitation (inability to sit still not related to ADHD or medication side effects; several nights without sleeping due to emotional agitation and/or delusions or paranoia; emotional lability with persistent pacing, with or without property damage, unresponsive to support or limits from others); or
 - A.1.2.3.7 Response to command/threatening hallucinations which could result in harm to self/others; or
 - A.1.2.3.8 Response to delusions, excessive preoccupations, or developmentally inappropriate inability to sort out fantasy from reality, which interfere with functioning and places child or others at risk (i.e., paranoid ideas that inspire retaliation; delusions of invincibility that lead child to place self in harm's way (e.g., slicing arm open to fix wires like "The Terminator")); or
 - A.1.2.3.9 Disorientation to person, place and time; or
 - A.1.2.3.10 Delirium; or
 - A.1.2.3.11 Dissociative events, which could result in harm to self/others.
- A.1.2.4 Acute Medical Risk: Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom(s) manifested by:
- A.1.2.4.1 Signs, symptoms, and behaviors that interfere with diagnosis or treatment of a serious medical illness requiring inpatient medical services (e.g., endocrine disorders such as diabetes and thyroid disease; cardiac conditions; etc.); or
 - A.1.2.4.2 A need for acute psychiatric interventions (i.e., drug, ECT, restraint) that have a high probability of resulting in serious and acute deterioration of physical and/or medical health; or
 - A.1.2.4.3 Not eating and/or excessive exercise to the point that further weight loss is medically threatening.
- A.1.2.5 Medication Adjustment: Patient has met any of the above symptoms within the past 12 months and requires a

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medication taper and re-evaluation in an inpatient hospital setting. Previous attempts to taper medication have resulted in behavioral escalations that meet admission criteria for inpatient hospitalization.

And meets at least one of the following criteria:

A.1.3 Intensity of Service Need

A.1.3.1 Individual requires inpatient psychiatric care with 24-hour medical management. The above symptoms cannot be contained, attenuated, evaluated and treated in a psychiatric residential treatment facility or lower level of care as evidenced by:

A.1.3.1.1 Psychiatric treatment (e.g., medication, ECT) presents a significant risk of serious medical compromise (e.g., ECT for a child with a cardiac condition, restraint or seclusion of a child with a cardiac condition, initiation of or change in neuroleptic medication for a child with history of neuroleptic malignancy syndrome, or administration of depakote to a child with a history of neutropenia); or

A.1.3.1.2 Patient requires or is likely to have diagnostic or evaluative procedures readily available in a hospital setting (e.g., MRI, 24-hour EEG, neurological examination, or specialized lab work, etc.); or

A.1.3.1.3 Intrusive route of medication administration requires medical management (e.g., intramuscular administration of PRN medication or administration by means of an NG tube); or.

A.1.3.1.4 Patient has had frequent (e.g., once every other day) restraints or seclusions or has recently had mechanical restraint; or

A.1.3.1.5 The administration of restraints or seclusions has required the involvement of three or more persons or presented high risk of serious injury to self or others; or

A.1.3.1.6 Patient requires 1:1 supervision or frequent checks for safety (e.g., every 15 minutes or less); or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

A.1.3.1.7 Efforts to manage medical risk symptom or behavior (see III.A.1.b.(4)) in a lower level of care are ineffective or result in an acute escalation of behavior with risk of harm to self or others; or

A.1.3.1.8 Requires close medical monitoring or skilled care to adjust dosage of psychotropic medications and such medical monitoring and dosage adjustment could not safely be conducted in a psychiatric residential treatment facility, residential treatment center, or ambulatory setting.

A.2.0 Continued Care Criteria

A.2.1 Patient has met admission criteria within the past 48 hours or has been prevented from engaging in qualifying behavior due to use of 1:1 supervision, frequent checks (q5), physical/mechanical restraint, or locked seclusion; or

A.2.2 Evidence of active treatment and care management as evidenced by:

A.2.2.1 Patient and family participation in treatment consistent with care plan, or active efforts to engage the patient and/or family are in process. Type, frequency, and intensity of services are consistent with the treatment plan, and

A.2.2.2 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored daily, and

A.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying and referring for aftercare or local systems of care or local DCF Managed Service System, scheduling initial aftercare appointments).

A.2.3 If the patient does not meet criterion A.2.1, continued stay may still be authorized under any of the following exceptional circumstances:

A.2.3.1 Patient has clear behaviorally defined treatment objectives that can reasonably be achieved within 30 days and are determined necessary in order for the discharge plan to be successful, and there is no other suitable environment in which the objectives can be safely accomplished; or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- A.2.3.2 Patient can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to the community rather than to another institutional setting; or
- A.2.3.3 Patient is expected to transfer to another institutional treatment setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement, can avoid disrupting care and compromising patient stability. Continued stays for this purpose may be as long as 30 days; or
- A.2.3.4 Patient is scheduled for discharge, but the patient's community-based aftercare plan is missing critical components. These components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, day treatment or partial hospital programs, etc.). Authorization may be extended for up to 30 days. In such cases, if it is reasonably determined that critical component of the discharge plan will not be available within 30 days, the patient should be discharged to a less restrictive level of care.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

B. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Definition

Psychiatric residential treatment facility (PRTF) is an inpatient psychiatric facility that provides psychiatric and other therapeutic and clinically informed services to individuals under age 21, whose immediate treatment needs require a structured 24 hour residential setting that provides all required services (including schooling) on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, parent guidance, substance abuse education/counseling (when indicated) and other support services including on site education, designed to assist the young person to achieve success in a less restrictive setting. This level of care primarily serves as a step down from acute psychiatric inpatient care. On occasion, it may be appropriate for children to be admitted directly from the community.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. The initial authorization generally covers thirty days. Subsequent reviews are generally required every thirty days. Extended stays may be subject to Intensive Care Management review.

Medical Necessity Criteria:

B.1.0 Admission Criteria

B.1.1 Symptoms and functional impairment include all of the following:

B.1.1.1 Diagnosable DSM Axis I or Axis II disorder,

B.1.1.2 Symptoms and impairment must be the result of a psychiatric or substance abuse disorder, excluding V-codes,

B.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation, and

B.1.1.4 GAF <40

B.1.2 Patient has recently met acute inpatient psychiatric criteria but has not met continued care criteria for the acute level of care. Child continues to demonstrate vulnerability to acute exacerbations as evidenced by intermittent acuity in hospital or history of rapid decompensation with transitions. Discharge to lower level of care would likely lead to the need for hospitalization.

B.1.3 Intensity of Service Need

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

B.1.3.1 The child meets criteria for discharge from a hospital setting but:

B.1.3.1.1 Key components of a residential or community based treatment plan are unavailable, or

B.1.3.1.2 All less restrictive treatment options have been examined and determined to be ineffective and the individual requires 24 hour supervised care within a psychiatrically staffed residential environment as evidenced by:

- Patient's behavior is sufficiently unstable to require immediate professional intervention to protect patient from harming self and others; or
- Patient is likely to require intermittent 1:1 supervision, constant observation, or frequent checks for safety; or
- Efforts to manage medical risk symptom or behavior in a lower level of care have been examined and determined to be ineffective or result in an acute escalation of behavior with risk of harm to self or others; or
- Patient requires close medical monitoring or skilled care to evaluate and adjust dosage of psychotropic medications and such medical management and dosage adjustment could not safely be conducted in a residential treatment center, or ambulatory setting; or
- Patient requires a medication taper and re-evaluation in a closely monitored setting. Previous attempts to taper medication have resulted in behavioral escalations that meet admission criteria for inpatient hospitalization.

B.2.0 Continued Care Criteria

B.2.1 Patient has met acute care criteria within past 30 days; and

B.2.2 There is evidence of active treatment and care management as evidenced by:

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- B.2.2.1 Patient and family participation in treatment consistent with care plan, or active efforts to engage the patient and/or family are in process. Type, frequency, and intensity of services are consistent with the treatment plan, and
 - B.2.2.2 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being *made and* monitored daily, and
 - B.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying and referring for aftercare or local systems of care, scheduling initial aftercare appointments).
- B.2.3 If the patient does not meet criterion F.2.1, continued stay may still be authorized under any of the following exceptional circumstances:
- B.2.3.1 Patient has clear behaviorally defined treatment objectives that can reasonably be achieved within 30 days and are determined necessary in order for the discharge plan to be successful, and there is no other suitable environment in which the objectives can be safely accomplished; or
 - B.2.3.2 Patient can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to the community rather than to another residential setting. Continued stays for this purpose may be as long as 30 days; or
 - B.2.3.3 Patient is expected to transfer to another institutional treatment setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement, can avoid disrupting care and compromising patient stability. Continued stays for this purpose may be as long as 30 days; or
 - B.2.3.4 Patient is scheduled for discharge, but the patient's community-based aftercare plan is missing critical components. These components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, day treatment or partial hospital programs, etc.). Authorization may be extended for up to 30 days with Intensive Care Management involvement. Under such circumstances, the ICM will work closely with the Managed Service System if the child is DCF involved or directly with the

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local providers or Community Collaboratives to address aftercare needs.

- B.2.3.5 Patient would be highly vulnerable to rapid decompensation if discharged to home due to significant known stressors within the home environment that would not be mitigated sufficiently with home-based or other clinical services.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

C. RESIDENTIAL TREATMENT CENTER:

Definition

A Residential Treatment Center (RTC) is a 24 hour facility licensed as such by the State of Connecticut or appropriately licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living within the parameters of clinically informed milieu and based on a well defined, individually tailored treatment plan. This level of care is reserved for those children/adolescents whose psychiatric and behavioral status warrants the structure and supervision afforded by a self contained setting that has the ability to offer all necessary services including an on-site educational program, and provide line of sight supervision *when necessary*. Clinical consultation is available at all times and physical restraint may be used in emergency situations, as necessary to prevent immediate or imminent injury to the client or others. RTC frequently serves as a step down from psychiatric hospitalization or may serve as the treatment of choice when a child's behavioral status places him or the community at risk should services be offered in a less restrictive setting.

Authorization Process and time Frame for Services

Admission to Residential Treatment requires the support of a DCF Area Office Director and the approval of the DCF Bureau of Behavioral Health, Medicine and Education. Each child/adolescent considered for this level of care must have had a Comprehensive Global Assessment (or other DCF approved evaluation) and any additional diagnostic services (i.e., face to face interview, psychological testing, medication evaluation, family interview) necessary to develop a complete clinical and psychosocial profile of the child's service needs. This level of care is authorized and reviewed in intervals appropriate to the treatment needs of the child/adolescent and the specific focus of the intervention.

Level of Care Guidelines:

C.1.0 Admission Criteria

- C.1.1 Severity of Symptoms and Functional Impairment,
- C.1.2 Diagnosable DSM-IV Axis I or Axis II disorder,
- C.1.3 Symptoms and impairment must be a result of a psychiatric or co-occurring substance abuse disorder, excluding V-codes, and
- C.1.4 Chronic (>6-months) presentation of the following behaviors consistent with at least one of the following,
 - C.1.4.1 Recurrent suicidal gestures and/or attempts with significant risk of self-injury; or

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- C.1.4.2 Recurrent self-mutilation that requires non-urgent medical intervention and that presents some potential for danger, e.g., through infection; or
- C.1.4.3 Recurrent deliberate attempts to inflict serious injury on another person; or
- C.1.4.4 Unremitting reckless behavior suggesting an unwillingness to consider potential for risk to self or others (e.g. fire setting, psychosexual behavior problems; reckless driving; and other risk-taking behavior;) or
- C.1.4.5 Unremitting impulsive, defiant, antagonistic or provocative behavior with potential for risk to self or others; or
- C.1.4.6 Recurrent agitated and uncontrolled behavior including acts of violence against property or persons; or
- C.1.4.7 Recurrent dangerous or destructive behavior; or
- C.1.4.8 Recurrent psychotic symptoms/behavior that pose a significant risk to the safety of the child/adolescent or others, or markedly impaired functioning in one or more domains; or
- C.1.4.9 Recurrent and marked mood lability resulting in severe functional impairment; or
- C.1.4.10 Recurrent intimidation/threats of aggression with moderate to high likelihood that they will be acted upon and result in serious risk to others.

C.2.0 Intensity of Service Need

- C.2.1 Individual requires residential treatment without 24-hour medical monitoring as evidenced by either:
 - C.2.1.1 The above symptoms cannot be contained, attenuated, evaluated and treated in a home type living situation with any combination of outpatient and intensive ambulatory services due to :
 - C.2.1.1.1 Child/Adolescent presents moderate risk for requiring restraint/seclusion as evidenced by the use of such during the 3-month period immediately preceding admission. Restraints were occasional (not more than once every two weeks), could be administered with fewer than 3 persons and did not

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present high risk of serious injury to self or others.
Seclusions were not locked; or

C.2.1.1.2 Patient requires 24-hour awake supervision in order to safely manage behaviors in above or due to high AWOL risk, or

C.2.1.2 Documented efforts to provide intensive community-based treatment (e.g., , extended day treatment/intensive outpatient treatment, home-based services, intensive intervention within the school environment) while the child is living in a home type setting.(,e.g., *birth, relative, adoptive, foster, therapeutic foster, or group home*) have been implemented within the past six months and have not resulted in safe, manageable behavior in the home setting; or

C.2.1.3 Necessary, less restrictive intensive community-based services needed to support the child/adolescent in a home setting are not currently available and clinical issues require this level of care as an appropriate alternative.

C.3.0 Continued Care Criteria

C.3.1 Severity of Illness

C.3.1.1 Symptoms and impairment must be a result of a psychiatric or substance abuse disorder, excluding V-codes, and

C.3.1.2 Clinical or treatment circumstances consistent with one of the following:

C.3.1.2.1 Child/Adolescent has exhibited behavior consistent with admission criteria within the past 6 weeks; or

C.3.1.2.2 Child/Adolescent has been prevented from engaging in above qualifying behavior due to use of 1:1 supervision, frequent checks (q15), physical/mechanical restraint or locked seclusion;
or

C.3.1.2.3 Child/Adolescent's history, current presentation, and treatment progress strongly suggest that discharge to a lower level of care presents a high likelihood of deterioration in the patient's condition, high-risk behavior, and the inability to continue to make progress on treatment goals. This might be evidenced by recent (e.g., past 8 weeks) history of

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failed attempts to transition from this level and type of care with adequate aftercare supports or deterioration in behavioral functioning during a recent period without this level of care, e.g., during holiday or day/multi-day passes

- C.3.2 If the child/adolescent does not meet the above criteria, continued treatment may still be authorized under the following circumstances:
- C.3.2.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved within 30 days and are determined necessary in order for the discharge plan to be successful, and there is no less restrictive environment in which the objectives can be safely accomplished; or
 - C.3.2.2 Child/adolescent can achieve certain treatment objectives including appropriate pharmacological treatment, in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to the community rather than to another restrictive setting; or
 - C.3.2.3 Child/adolescent is expected to transfer to another residential setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement can avoid disrupting care and compromising the stability of the child/adolescent. Continued stays for this purpose may be as long as 30 days; or
 - C.3.2.4 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, therapeutic mentoring, etc.). Referral to the child's DCF Area Office for review by the Managed Service System is indicated.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

D. THERAPEUTIC GROUP HOME: LEVEL II

Definition

A Level II Therapeutic Group Home (TGH) is a small, four- to- six bed, DCF or DMR licensed program located in a neighborhood setting with intensive staffing level and services offered within the context of a 24/7 home-like milieu. It is a highly structured treatment program that creates a physically, emotionally and psychologically safe environment for children and adolescents with complex behavioral health needs who need additional support and clinical intervention to succeed in either a family environment or in an independent living situation. A Level II TGH is designed to serve as a step-down from inpatient level of care, or as a step-down from or alternative to residential level of care. Education is provided off site through the local education authority. Community based activities (recreational, vocational, social development) serve as a focus for clinical and rehabilitative intervention. As such, the Level II TGH is designed to develop and promote optimal functioning within the context of a normative environment utilizing highly specific individualized treatment. A Level II TGH is *not* to be used solely for the purpose of housing/care/custody or as an alternative to incarceration.

Authorization Process and Time Frame for Services:

This level of care requires prior authorization. Referral for admission to this level of care requires the approval of a DCF Area Office Director and the approval of the DCF Bureau of Behavioral Health, Medicine and Education and authorization by the ASO. Each child/adolescent considered for this level of care must have had a Comprehensive Global Assessment (CGA) or DCF approved equivalent and any additional diagnostic service (i.e., face to face interview, psychological testing, medication evaluation, family interview) necessary to develop a complete clinical and psychosocial profile of the child/adolescent's service needs. The CGA will support the development of a treatment plan that will identify any individual service needs that require clinical and rehabilitative intervention within the group home. This level of care is authorized and reviewed in intervals appropriate to the treatment needs of the child/adolescent and the specific focus of the intervention.

Level of Care Guidelines

D.1.0 Admission Criteria

D.1.1 Symptoms and Functional Impairment include:

D.1.1.1 Diagnosable DSM-IV Axis I or Axis II Disorder, and

D.1.1.2 Symptoms are primarily the result of a psychiatric disorder, excluding V-codes. Mental Retardation and Substance Abuse may be co-occurring, and

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- D.1.1.3 Symptoms and impairment are the result of Pervasive Developmental Disorder or Mental Retardation, and
- D.1.1.4 GAF < 60, and
- D.1.1.5 Child /Adolescent requires 24 hour structured therapeutic milieu due to chronic (greater than 6 month) presentation of at least *one* of the following behaviors:
 - D.1.1.5.1 Past history of suicidal and/or homicidal thoughts and/or impulses with significant current ideation without intent or conscious plan; or
 - D.1.1.5.2 Frequent and severe verbal or physical aggression directed toward self and others that interferes with development of successful interpersonal relationships; or
 - D.1.1.5.3 Episodic impulsivity and/or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g., status offenses, AWOL, self injurious behavior, fire setting, violence toward animals) or
 - D.1.1.5.4 Recurrent psychotic symptoms/behavior that pose a significant risk to the safety of the child/adolescent or others, or markedly impaired functioning in one or more domains
- D.1.1.6 And one of the following conditions:
 - D.1.1.6.1 Moderate to severe functional problems in school/vocational setting or other community setting (e.g., school suspension, involvement with the law) due to inability to accept age appropriate direction or supervision from caretakers; or
 - D.1.1.6.2 Chronic medical condition that requires assistance to achieve compliance with prescribed medical regimen (e.g., diabetes treatment, asthma treatment); or
 - D.1.1.6.3 Demonstrated inability to form trusting relationships with caregivers (including regular and specialized foster care) that prohibit success in a family setting; or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

D.1.1.6.4 Demonstrated inability to tolerate a large
congregate care setting (e.g., larger than six beds)

D.1.2 Intensity of Service Need

D.1.2.1 The child or adolescent is can not be treated in a *family* setting with a combination of outpatient and intensive ambulatory services due to demonstrated low tolerance for family environment or marked intolerance for adult authority as evidenced by one of the following:

D.1.2.1.1 Two or more failures in home or foster home settings with intensive community based services and supports due to disruptive behavior that has placed child, caregivers or other members of the household at risk for injury to person or property; or

D.1.2.1.2 Qualitative impairment in social interaction, lack of social/emotional reciprocity, failure to develop peer relations appropriate to developmental level and/or a profound mistrust of others due to previous trauma or pervasive developmental disorder, and

D.1.2.1.3 Child/Adolescent requires specialized and intensive clinical and rehabilitative intervention provided by trained staff to achieve optimal control over emotions and to exhibit behavior appropriate to age and community expectations or

D.1.2.1.4 Child/Adolescent is vulnerable to crisis and may require access to on site 24 hour emergency evaluation and crisis intervention and

D.1.2.1.5 Child/Adolescent is able to attend off site educational placement

D.2.0 Continued Care Criteria

D.2.1 Severity of Illness

D.2.1.1 Symptoms and impairment must be the result of a psychiatric or substance abuse disorder, excluding V-codes, and

D.2.1.2 Clinical or treatment circumstances consistent with one of the following:

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- D.2.1.2.1 Child/Adolescent has exhibited behavior consistent with admission criteria within the past 60 day; or
 - D.2.1.2.2 Child/Adolescent has been hospitalized for symptoms that preclude a lower level of care within the past 30 days; or
 - D.2.1.2.3 Child/Adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals, and
- D.2.1.3 There is evidence of active treatment and care management as evidenced by:
- D.2.1.3.1 A care plan has been established with treatment objectives appropriate for this level of care. Treatment objectives are related to improved behavioral and social/emotional functioning, and are tied to the child's long-range permanency plan (e.g., return to home, discharge to foster care, independent living, or alternative treatment setting within the adult system). Progress toward objectives is being monitored at a level appropriate to child's permanency needs, and
 - D.2.1.3.2 Child's participation in treatment is consistent with care plan or active efforts to engage child are in process. Type, frequency and intensity of services are consistent with treatment plan, and
 - D.2.1.3.3 Vigorous efforts are being made to affect a timely discharge to the next level of care (e.g., lower level group home, transitional living program, independent living, foster family, biological family) including, but not limited to case conferences and appointments with aftercare providers, clinical interventions with future caregivers, educational/vocational planning as indicated.
- D.2.1.4 If the child/adolescent does not meet above criteria, continued stay may still be authorized under the following circumstances:
- D.2.1.4.1 Child/Adolescent has clear, behaviorally defined treatment objectives that can reasonably be achieved within 30 days and are determined necessary in order for the discharge plan to be successful, and there is no less restrictive

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

environment in which the objectives can be safely accomplished; or

- D.2.1.4.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged to a less restrictive community-based setting; or
- D.2.1.4.3 Child/Adolescent is expected to transfer to a less restrictive community-based setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement can avoid disrupting care. Continued stays for this purpose may be as long as 30 days; or
- D.2.1.4.4 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to therapist appointments, therapeutic mentoring, etc.) Referral to the child's DCF Area Office for review by the Managed Service System is indicated; or
- D.2.1.4.5 Child/Adolescent has been approved for long term placement in the Therapeutic Group Home as part of the DCF Permanency Plan which has been approved by the DCF Area Office and DCF Bureau Chief for Behavioral Health, Medicine and Education.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

E. INTERMEDIATE CARE

Definition

Intermediate care refers to a continuum of ambulatory psychiatric treatment programs that offer intensive, coordinated and structured therapeutic and assessment services within a stable therapeutic milieu. These programs encompass partial hospital (PHP), intensive outpatient (IOP) and extended day treatment (EDT) levels of care. All programs require psychiatric evaluation, treatment planning and oversight and serve as a step down to, or diversion from, inpatient levels of psychiatric care. Multiple treatment modalities (i.e., individual therapy, group therapy, family therapy, medication management, therapeutic recreation) are integrated within a single treatment plan that focuses on patient specific goals and objectives. Services are office based although some programs may allow for structured off -site activity. Programs vary according to intensity of service (day/hours offered weekly) and length of stay.

Authorization Process and Time Frame for Service

This level of care requires prior authorization. Time frame for initial authorization is individualized according to intensity of client need and type of program for which admission is sought. Generally, PHP and IOP provide more intensive service over a brief period of time to stabilize a client's functioning, while EDT offers clinical intervention and rehabilitative services over a longer period of time to help the patient achieve success in a less restrictive setting that incorporates community-based activities into the treatment plan. Some IOP level services are specialized in clinical focus or treatment model and are operated as intensive service components of outpatient clinics.

Use of Guidelines

The following guidelines are to be used when determining access to any of these three levels of Intermediate Care. Differences in admission, intensity of service need, and continued care for each of these three services are addressed in the service grid to be used conjointly with these guidelines.

Level of Care Guidelines

E.1.0 Admission Criteria

E.1.1 Symptoms and functional impairment include all of the following:

E.1.1.1 Diagnosable DSM Axis I or Axis II disorder,

E.1.1.2 Symptoms and impairment must be the result of a primary psychiatric disorder, excluding V-codes; substance abuse disorders may be secondary,

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- E.1.1.3 Symptoms and impairment must be the result of a psychiatric disorder, excluding V-codes,
- E.1.1.4 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation, and
- E.1.1.5 Acute onset or exacerbation of an illness or persistent presentation (e.g., over 6 month period) of at least one of the following **Symptom Categories:**
 - E.1.1.5.1 Suicidal gestures or attempts or suicidal ideation or threats that are serious enough to lead to suicidal attempts; or
 - E.1.1.5.2 Self-mutilation that is moderate to severe and dangerous; or
 - E.1.1.5.3 Deliberate attempts to inflict serious injury on another person; or
 - E.1.1.5.4 Dangerous or destructive behavior as evidenced by episodes of impulsive or physically or sexually aggressive behavior that present a moderate risk; or
 - E.1.1.5.5 Psychotic symptoms or behavior that poses a moderate risk to the safety of the child or others; or
 - E.1.1.5.6 Marked mood lability as evidenced by frequent or abrupt mood changes accompanied by verbal or physical outbursts/aggression; or
 - E.1.1.5.7 Marked depression or anxiety as evidenced by significant disruption of activities of daily living or relationships with families and peers.

And meets at least one of the following criteria:

E.1.2 Intensity of Service Need

- E.1.2.1 The child or youth requires an organized, structured program several days each week. The intensity of service and the length of stay vary according to the child's needs and the program type. The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:
 - E.1.2.1.1 One or more recent efforts to provide or enhance outpatient treatment have been unsuccessful; or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

E.1.2.1.2 Recent attempts to engage the child and/or family in outpatient therapy have been unsuccessful or the patient and caregivers have been noncompliant with treatment; or

E.1.2.1.3 The child/adolescent is acutely symptomatic and needs to be stepped down or diverted from inpatient level of care. Child/adolescent remains moderately to severely symptomatic and there is a high likelihood that the child/adolescent's condition would deteriorate if treated in a lower level of care.

Program Specific Requirements:

PHP: Child/adolescent demonstrates severe and disabling level of symptomatology that severely impairs the child/adolescent's capacity to function adequately in multiple areas of life on a day-to-day basis. It is highly likely that the child/adolescent will require an inpatient level of care or will quickly deteriorate to a level of functioning that would require an inpatient admission without the intensive daily services of the PHP level of care. The child/adolescent requires at 4-6 hours/day of structured programming five days a week for a brief period of time. May need continued diagnostic work and medication evaluation. May have been unsuccessful in IOP or other day program.

IOP: Child/adolescent demonstrates moderate level of symptomatology that has a moderate impact on the child/adolescent's capacity to function adequately in multiple areas of life on a day-to-day basis. The child/adolescent is at substantial risk for further decompensation, deterioration or self-harm and inpatient hospitalization without IOP services. Child/adolescent requires 2-4 hours/day of structured programming for 2-5 days per week for a brief period of time. Some specialized IOP programs may require longer lengths of stay. Requires little or no additional diagnostic work but may require medication management. Has been unsuccessful in out patient or other community based programs.

EDT: Child/adolescent demonstrates moderate level of symptomatology that appears to be persistent in nature (i.e., greater than six months) although may be the result of an acute exacerbation of symptoms and lack of success in shorter term intermediate programs, intensive home-based programs or other community –based services.

E.2.0 Continued Care Criteria

E.2.1 Patient has met admission criteria within the past three (3) days for PHP, five (5) days for IOP, and thirty (30) days for EDT evidenced by:

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- E.2.1.1 The child or youth's symptoms or behaviors persist at a level of severity documented at the most recent start for this episode of care; or
 - E.2.1.2 The child or youth has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals, and
- E.2.2 Evidence of active treatment and care management as evidenced by:
- E.2.2.1 A care plan has been established with evaluation and treatment objectives appropriate for this level of care. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and
 - E.2.2.2 Child and caregiver participation in treatment is consistent with care plan or active efforts to engage the child and caregiver are in process. Type, frequency and intensity of services are consistent with treatment plan, and
 - E.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments)
- E.2.3 If child/adolescent does not meet above criteria, continued stay may still be authorized under any of the following circumstances:
- E.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved within 5 days for PHP, 10 days for IOP and 30 days for EDT, and are determined necessary in order for the discharge plan to be successful, and there is not suitable lower level of care in which the objectives can be safely accomplished; or
 - E.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to the community rather than to a more restrictive setting; or
 - E.2.3.3 Child/adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, day treatment or intensive outpatient treatment etc.) Authorization may be extended in increments for up to 5 days for PHP, 10 days for IOP and up to 30 days for EDT. Under such circumstances, the Intensive Care Manager will work closely with the Managed Service System if the child is DCF involved or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

directly with local providers or Community Collaboratives to address aftercare needs.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

**Intermediate Levels of Care –
Partial Hospital, Intensive Outpatient, Extended Day Treatment**

| Aspects of Care | Partial Hospitalization | Intensive Outpatient | Extended Day Treatment |
|---|--|---|---|
| Hours Per Day | 4 –6 Hours Per Day | 2-4 Hours Per Day | 3-5 Hours Per Day |
| Days Per Week | 5 Days per week | 2-5 Days per week | 2-5 Days per week |
| GAF | <50 | <55 | <55 |
| Medical Oversight | Participants are under the care of a physician who directs treatment. Client requires frequent medical monitoring, adjustments and observation of side effects on daily basis by medically trained staff. Typically involves daily rounds. | Participants are under the care of a physician who directs treatment. Client may require medical monitoring, adjustments and observation of side effects by medically trained staff. | Participants are under the care of a physician who directs treatment. Client may require medical monitoring, adjustment and observations of side effects by medically trained staff. |
| Community Based Therapeutic Recreation | Rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) may be incorporated into the milieu. Services are provided on-site, the goals are short-term. | Rehabilitative therapies (i.e., activities that restore social skills, age appropriate activities of daily living) may be incorporated into the milieu. Services are provided on-site, the goals are short-term. | Rehabilitative therapies (i.e., activities that restore social skills, age appropriate activities of daily living) are a major focus of the program (typically 2 hours of each 3 hour day) and occur onsite and offsite with the primary goal of reintegration into community based activities. |
| Therapy | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family therapy provided at least 1x weekly unless contraindicated. | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family therapy provided at least 1x weekly unless contraindicated. | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family involvement in treatment is expected. |
| Target Length of Stay | 2-4 weeks | 2-6 weeks | Up to 6 months |
| Clinical Intensity | Child/adolescent demonstrates severe level of symptomatology requiring 4-6 hours/day of structured programming five days a week for brief period of time. May need continued diagnostic work and medication evaluation. May have been unsuccessful in IOP or other day program or may have recently been released from inpatient level of care or may have recently been unsuccessful in outpatient level of care. | Child/adolescent demonstrates moderate level of symptomatology requiring 2-4 hours/day of structured programming for 3-5 days per week for a brief period of time. Requires little or no diagnostic work but may require medication management. Has been unsuccessful in outpatient or other community based programs or is stepping down from PHP or inpatient level of care and meets admission criteria for IOP level of care. | Child/adolescent demonstrates moderate level of symptomatology that appears to be persistent in nature (i.e., greater than six months) and lack of success in shorter-term intermediate programs or other community-based programs. |

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

F. INTENSIVE IN HOME CHILDREN AND ADOLESCENT PSYCHIATRIC SERVICES

Definition

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) is a manualized treatment model designed to prevent children and adolescents from psychiatric hospitalization or institutionalization or to support discharge from inpatient levels of care. While children with psychiatric symptoms are the focus of intervention, the model address and intervenes with the domains that impact the child most directly: family, school, community resources and service systems.

IICAPS is an intensive, home-based service designed to address specific psychiatric disorders in the identified child, while remediating problematic parenting practices and/or addressing other family challenges that effect the child and family's ability to function. Efforts are also made within the service to improve the child's educational programming and to ameliorate any environmental factors that may contribute to the child's psychosocial adversity. IICAPS teams are expected to spend a minimum of five hours per week working directly with children and their families and managing their care. Children receiving IICAPS services are likely to be recipients of concurrent services from other mental health providers. These providers are expected to work in collaboration with the IICAPS team during the IICAPS intervention. Their involvement with the child and family often extends beyond the IICAPS Episode of Care.

Authorization Process and Time Frame for Service

This level of care requires prior authorization and can only be provided by a treatment provider who is certified by the Department of Children and Families as an IICAPS provider.

Authorization is typically provided on a monthly basis in bundles of eighty-eight (88) units per authorization. Services may last up to six months or beyond with special review.

Level of Care Guidelines

F.1.0 Admission Criteria

F.1.1 Symptoms and functional impairment include all of the following:

F.1.1.1 Diagnosed DSM Axis I or Axis II disorder,

F.1.1.2 Symptoms and impairment must be the result of a primary psychiatric disorder, excluding V-codes; substance abuse disorders may be secondary.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- F.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation, and
- F.1.1.4 GAF <55
- F.1.2 Presentation consistent with at least one of the following:
 - F.1.2.1 Recent and/or ongoing suicidal gestures and/or attempts; or
 - F.1.2.2 Recent and /or ongoing self-mutilation that is severe and dangerous; or
 - F.1.2.3 Recent and/or ongoing risk of deliberate attempts to inflict serious injury on another person; or
 - F.1.2.4 Recent and/or ongoing dangerous or destructive behavior as evidenced by indication of episodic impulsivity or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g., impulsive acts while intoxicated, self mutilation, running away from home or placement with voluntary return, fire setting, violence toward animals, affiliation with dangerous peer groups); or
 - F.1.2.5 Recent and/or ongoing psychotic symptoms or behavior that poses a moderate risk to the safety of the child or others (e.g., hallucination, marked impairment of judgment); or
 - F.1.2.6 Recent and/or ongoing marked mood lability as evidenced by frequent or abrupt mood changes accompanied by verbal or physical outbursts/aggression and/or destructive behaviors or marked depression, anxiety, or withdrawal from activities and relationships and peers
- F.1.3 Children appropriate for IICAPS services are those for whom:
 - F.1.3.1 There is a family resource that is available, willing and able to participate in this intensive home-based intervention
 - F.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety
 - F.1.3.3 It is possible to willingly enter into a reliable contract for safety (applicable only when a developmentally appropriate expectation)
- F.1.4 Intensity of Service Need
 - F.1.4.1 The child's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

treatment approach that involves family members as primary intervention specialists

F.1.4.2 The child has been admitted to, or is at risk of being admitted to a psychiatric inpatient unit or is being discharged from a residential treatment center and demonstrated the above admission criteria prior to placement.

F.1.4.3 The child is either in out of home care and requires intensive in-home care as part of the individual care plan or is at high risk for out of home care.

F.1.4.4 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:

F.1.4.4.1 Recent attempts to engage the child and/or family in therapy have been unsuccessful due to transportation issues and/or other family constraints that interfere with ability to keep appointments on a consistent basis; or

F.1.4.4.2 The above problems occur in context of a regular and significant outpatient therapeutic relationship despite efforts to augment such treatment (e.g., medication consultation or increased outpatient therapy visits or addition of family/parent therapy, psychological assessment, group therapy, etc).

F.2.0 Continued Care Criteria

F.2.1 Patient has met admission criteria within the past thirty (30) days for IICAPS as evidenced by:

F.2.1.1 The child or youth's symptoms or behaviors persist at a level of severity documented at the start of this episode of care; or

F.2.1.2 The child or youth has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or

F.2.2 Evidence of active treatment and care management as evidenced by:

F.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- F.2.2.2 Child and family (caregiver) participation in treatment is consistent with care plan, or active efforts to engage the patient and/or family are in process. Type, frequency and intensity of services are consistent with treatment plan, and
 - F.2.2.3 Vigorous efforts are being made to affect a timely transition to outpatient care (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments).
 - F.2.2.4 Children receiving IICAPS services can receive concurrent treatment from other mental health providers including but not limited to out-patient, extended day, and partial hospital services if deemed appropriate in the treatment plan.
- F.2.3 If child/adolescent does not meet criterion E.3.1, continued treatment may still be authorized under any of the following circumstances:
- F.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through continued home based treatment and such treatment is necessary in order for the discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or
 - F.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to a less intensive community rather than to a more restrictive setting; or
 - F.2.3.3 Child/adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, therapeutic mentoring, etc). Authorization may be extended for up to 10 days. Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with Managed Service System if child is DCF involved or directly with local providers or Community Collaboratives to address aftercare needs).

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

G. MULTIDIMENSIONAL FAMILY THERAPY

Definition

Multidimensional Family Therapy (MDFT) is a Family-focused, ecologically oriented evidence-based model shown effective in treatment of children/adolescents between the ages of 11 – 17.5 with substance abuse and/or dependence issues, or children/adolescents with substance abuse/dependence issues and co-morbid psychiatric issues. MDFT is designed to reduce the influence of factors that place a child/ adolescent at risk for substance abuse while strengthening the presence of protective factors, such as supporting a positive parent-child relationship.

MDFT was developed at the University of Miami and targets several facets in a child/adolescent's life in order to alleviate the presenting problems of drug abuse and co-morbid psychiatric issues. The approach combines clinical intervention with case management type activity and assumes change to be multi-determined. MDFT will work with parents and youth to facilitate compliance with any prescribed medications and psychiatric medication.

Interventions are multidimensional and include the child/adolescent and/or the parent, family members, and representatives from systems external to the family (e.g., education, juvenile justice, peers, social services). It is expected that interventions are inclusive of all family and environmental influences that affect the individual child or adolescent's success within treatment.

Authorization Process and Time Frame for Service

This level of care requires pre-authorization and can only be provided by a treatment provider who is authorized and credentialed through the University of Miami, MDFT credentialing process and certified by DCF to provide this service. In addition, on-going participation in the MDFT consultation and training from the state based MDFT certification center is required for all MDFT providers. The number of sessions will be dictated by the needs of the adolescent and family, but typically is not to be less than three contacts (2 hours/contact) per week, or 101 units (15 minutes per unit) per month (4.2 weeks). Typically, services can last from four to six months. Drug screens are conducted on a routine basis by therapist or case-manager, but results are not shared externally.

Level of Care Guidelines

G.1.0 Admission Criteria

G.1.1 Symptoms and functional impairment include all of the following:

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- G.1.1.1 Diagnosable DSM IV Axis I or Axis II disorder,
 - G.1.1.2 Symptoms and impairment must be the result of a primary substance abuse disorder, or the child/adolescent must be at risk of substance abuse with co-occurring Oppositional Defiant Disorder or Conduct Disorder. Other psychiatric issues can be present but secondary,
 - G.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation,
 - G.1.1.4 GAF <55, and
 - G.1.1.5 IQ > 65
- G.1.2 Presentation consistent with substance abuse or risk of substance abuse and at least one of the following:
- G.1.2.1 Recent and /or ongoing emotional and/or behavioral problems that are severe and potentially dangerous; or
 - G.1.2.2 Recent and/or ongoing involvement with legal system (status offenses, impulsive acts, running away from home) or
 - G.1.2.3 Recent and/or ongoing behaviors that pose a moderate risk to the safety of the child or others (e.g., depression marked impairment of judgment); or
 - G.1.2.4 Withdrawal from activities and relationships with peers and family member
- G.1.3 Children/Adolescents appropriate for MDFT services are those for whom:
- G.1.3.1 A family resource is available to participate in the treatment program, and
 - G.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety, and
 - G.1.3.3 A crisis plan has been developed.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

G.1.4 Children/Adolescents for whom MDFT is **not** medically appropriate, are those children/adolescents who currently demonstrate any of the following:

G.1.4.1 Child/Adolescent is actively suicidal (ideation and plan); or

G.1.4.2 Child/Adolescent currently exhibits a psychotic disorder (or features); or

G.1.4.3 Primary presenting problem is an eating disorder; or

G.1.4.4 Child/Adolescent engages in fire setting activity; or

G.1.4.5 The child's problems in functioning are primarily a function of current abusive and neglectful home environment (refer to Family Preservation); or

G.1.4.6 The family 's primary need is for respite, social support and/or social welfare service

G.1.5 Intensity of Service Need

G.1.5.1 The child/adolescent has been admitted to, or is at risk of being admitted to a residential treatment program, or detention facility; or

G.1.5.2 The child/adolescent has had frequent (i.e., four times within a 6 month period) visits to a emergency room setting due to disruptive behavior; and

G.1.5.3 The child's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves family members, school, peers, other systems as primary intervention specialists, and

G.1.5.4 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:

G.1.5.4.1 Recent attempts to engage the child/adolescent and/or family in outpatient therapy have been unsuccessful due to transportation issues and/or other family constraints that interfere with ability to keep appointments on a consistent basis; or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

G.1.5.4.2 The above problems occur in context of a regular and significant outpatient therapeutic relationship despite efforts to augment such treatment (e.g., medication consultation or increased outpatient therapy visits or addition of family/parent therapy, psychological assessment, group therapy, etc) or

G.1.5.4.3 The child/adolescent is in out-of-home care and requires intensive home based care to achieve the reintegration plan

G.2.0 Continued Care Criteria

G.2.1 Child/Adolescent has met admission criteria for the previously approved level of MDFT as evidenced by:

G.2.1.1 The child /adolescent 's symptoms or behaviors persist at a level of severity documented at the most recent start for this episode of care; or

G.2.1.2 The child/adolescent's symptoms or behaviors persist at a level of severity adequate to meet admission criteria; or

G.2.1.3 The child/adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or

G.2.1.4 The child /adolescent's symptoms have increased sufficiently over the past 24 hrs to warrant immediate increase of number of hours provided weekly to the family, and

G.2.2 Evidence of active treatment and care management as evidenced by:

G.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and

G.2.2.2 Child and family (caregiver) participation in treatment is consistent with care plan, or active efforts to engage the patient and/or family are in process. Type, frequency and intensity of services are consistent with treatment plan, and

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

G.2.2.3 Vigorous efforts are being made to affect a timely transition to outpatient care (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments).

G.2.3 If child/adolescent does not meet criterion E.2.1, continued treatment may still be authorized under any of the following circumstances:

G.2.3.1 Child/Adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through home-based treatment and continued home based treatment in current setting is determined necessary in order for the discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or

G.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives is necessary to enable the patient to be discharged to a less intensive level of care; or

G.2.3.3 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, clinical and non clinical support, day treatment or intensive outpatient treatment etc). Authorization may be extended for up to 10 days. Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with Managed Service System if child is DCF involved or directly with local providers or Community Collaboratives to address aftercare needs).

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

H. MULTISYSTEMIC THERAPY

Definition

Multisystemic Therapy (MST) is an evidenced based treatment model designed to divert children and adolescents ages 11 to 17 from residential substance abuse and juvenile justice treatment systems or to support discharge from inpatient levels of care. While children/adolescents with disruptive behavioral and/or substance abuse symptoms are the focus of intervention, the model relies on ecological, family and systemic interventions to assist in the reduction of symptoms.

MST is an intensive home-based delivery system with an emphasis on the engagement and retention of the family, the recovery environment, and providing integrated case management. MST has developed fidelity measures based on research and MST principles as well as quality assurance systems to manage program drift.

Authorization Process and Time Frame for Service

This level of care requires prior authorization and can only be provided by a treatment provider who is an MST credentialed provider, certified by the Department of Children and Families.

MST services typically last 4 months. The number of sessions per week will be dictated by the needs of the child/adolescent, but contact (2 hours/session) is typically at least three times per week for a minimum of 101 units (15min/unit) per month (4.2.weeks). Services may last up to six months or beyond with special review.

Level of Care Guidelines

H.1.0 Admission Criteria

- H.1.1 Symptoms and functional impairment include all of the following:
 - H.1.1.1 Diagnosable DSM Axis I or Axis II disorder,
 - H.1.1.2 Symptoms and impairment must be the result of a primary substance abuse and/or disruptive behavior disorder: internalizing psychiatric conditions may be secondary.
 - H.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation,

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

H.1.1.4 GAF<60

H.1.2 Presentation consistent with at least one of the following:

H.1.2.1 Recent and/or ongoing risk of deliberate attempts to inflict serious injury on another person; or

H.1.2.2 Recent and/or ongoing dangerous or destructive behavior as evidenced by indication of episodic impulsivity or physically or sexually aggressive impulses that are endangering to self or others (e.g., impulsive acts while intoxicated, running away from home or placement with voluntary return, fire setting, violence toward animals, affiliation with dangerous peer groups); and

H.1.2.3 Recent and/or ongoing substance abuse or dependency problem that is interfering with the adolescent's psycho-social functioning in the community

H.1.3 Children/Adolescents appropriate for MST services are those for whom:

H.1.3.1 There is a family/caregiver resource that is available to participate in this intensive home-based intervention, and

H.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety, and

H.1.3.3 A safety plan has been established, and

H.1.3.4 The primary presenting problem is not an internalizing disorder or the child/adolescent is not actively psychotic or suicidal.

H.1.4 Intensity of Service Need

H.1.4.1 The child/adolescent has been admitted to, or is at risk of being admitted to a substance abuse and/or Juvenile Justice residential level of care or is being discharged from a treatment center and demonstrated the above admission criteria prior to placement and

H.1.4.2 The child/adolescent's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves family members as primary intervention specialists and

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- H.1.4.3 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:
 - H.1.4.3.1 Recent attempts to engage the child and/or family in intensive outpatient therapy have been unsuccessful or
 - H.1.4.3.2 The above problems occur in context of the ecology and recovery environment is a significant factor to initiate and maintain clinical gains or
 - H.1.4.3.3 The child/adolescent is in out of home care and requires intensive in-home care to achieve the reintegration plan.

H.2.0 Continued Care Criteria

- H.2.1 The child/adolescent has met admission criteria within the past thirty (30) days for MST as evidenced by:
 - H.2.1.1 The child/adolescent's symptoms or behaviors persist at a level of severity adequate to meet admission criteria, or
 - H.2.1.2 The child/adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or
 - H.2.1.3 The child/adolescent 's symptoms have increased sufficiently over the past 24 hours to warrant immediate increase of number of hours provided weekly to the family and
- H.2.2 Evidence of active treatment and care management as evidenced by:
 - H.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and
 - H.2.2.2 Child/adolescent and family (caregiver) participation in treatment is consistent with care plan, or active efforts to engage the patient and/or family are in process. Type,

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

frequency and intensity of services are consistent with treatment plan, and

H.2.2.3 Vigorous efforts are being made to affect a timely transition to appropriate lower level of care.

H.2.3 If child/adolescent does not meet criterion E.2.1, continued treatment may still be authorized under any of the following circumstances:

H.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through continued home based treatment and such treatment is necessary in order for the discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or

H.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to a less intensive community rather than to a more restrictive setting; or

H.2.3.3 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, substance abuse treatment or therapist appointments, therapeutic mentoring, etc). Authorization may be extended for up to 10 days. Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with Managed Service System if child is DCF involved or directly with local providers or Community Collaboratives to address aftercare needs).

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

I. FUNCTIONAL FAMILY THERAPY

Definition

Functional Family Therapy (FFT) is a manualized treatment model designed to prevent children and adolescents ages 11-17, from requiring psychiatric hospitalization or residential placement or to support discharge from these out-of-home levels of care. The FFT model is a home-based service designed to address both symptoms of serious emotional disturbance in the identified child as well as parenting practices and/or other family challenges that affect the child and family's ability to function. During the FFT intervention, efforts are made to address areas in addition to child functioning and family relationships that may contribute to the child's psychosocial adversity. Particular areas include the school environment as well as the family's involvement with formal and naturalistic supports and services.

It is expected that FFT clinicians will take an active role in working directly with children and their families as well as in managing their care and facilitating health-enhancing connections in the community.

Authorization Process and Time Frame for Service

This level of care requires prior authorization and can only be provided by a treatment provider who is credentialed as an FFT provider and certified by the Department of Children and Families as an FFT provider.

The number of sessions varies according to the individual needs of the child/adolescent and family. However, authorization is typically provided on a monthly basis in bundles of 50 units (15 min/unit) to reflect 3 hrs per week for 4.2 weeks per month.

Authorization of significant additional hours per week may be required in certain instances to respond to the needs of the child and family. In these cases, more frequent review with a care manager will be required. Services typically last up to four months, or beyond with special review.

This level of care may be concurrently authorized with other levels of care such as outpatient, intensive outpatient or extended day treatment based on the individual needs of the child and family. This level of care may not be authorized concurrently with other intensive home-based behavioral health services, including Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), and Family Support Teams (FST).

Level of Care Guidelines

I.1.0 Admission Criteria

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- I.1.1 Symptoms and functional impairment include all of the following:
 - I.1.1.1 Diagnosed DSM-IV Axis I or Axis II disorder,
 - I.1.1.2 Symptoms and impairment must be the result of a primary psychiatric disorder, excluding V-codes; substance abuse disorders may be secondary
 - I.1.1.3 Functional impairment not solely a result of Pervasive Developmental Disorder or Mental Retardation
 - I.1.1.4 GAF <60
- I.1.2 *Presentation consistent with at least one of the following:*
 - I.1.2.1 Recent and/or ongoing marked depression, anxiety, or withdrawal from activities and relationships and peers; or
 - I.1.2.2 Recent and/or ongoing marked mood lability as evidenced by frequent or abrupt mood changes accompanied by verbal or physical outbursts/aggression and/or destructive behaviors; or
 - I.1.2.3 Recent and/or ongoing dangerous or destructive behavior as evidenced by episodic impulsivity or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g., impulsive acts while intoxicated, self injurious behavior, running away from home or placement with voluntary return, fire setting, violence toward animals, affiliation with dangerous peer groups).
- I.1.3 *Children/Adolescents appropriate for FFT services are those for whom:*
 - I.1.3.1 There is a family/caregiver resource that is available and willing and able to participate in this intensive home-based intervention, and
 - I.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety, and
 - I.1.3.3 There is a crisis plan in place, and
 - I.1.3.4 The primary presenting problem is *not* recent and/or ongoing suicidal gestures and/or attempts; or recent and /or ongoing self-injurious behavior that is serious and dangerous; or recent and/or ongoing risk of deliberate attempts to inflict serious injury on another person; or recent and/or ongoing psychotic symptoms or behavior that poses a moderate risk to the safety

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

of the child or others (e.g., hallucination, marked impairment of judgment). (If these symptoms are present, refer child to IICAPS or FST.)

I.1.4 Intensity of Service Need

I.1.4.1 The child's successful maintenance or reintegration in the community is dependent upon an integrated and coordinated treatment approach that involves family members as primary intervention specialists; and

I.1.4.2 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:

I.1.4.2.1 Recent attempts to engage the child and/or family in outpatient therapy have been unsuccessful due to transportation issues and/or other family constraints that interfere with ability to keep appointments on a consistent basis; or

I.1.4.2.2 The above problems occur in the context of a regular and significant outpatient therapeutic relationship despite efforts to augment such treatment (e.g., medication consultation or increased outpatient therapy visits or addition of family/parent therapy, psychological assessment, group therapy, etc.) or

I.1.4.2.3 The child is in out of home care and requires intensive home-based care to achieve the reintegration plan

I.2.0 Continued Care Criteria

I.2.1 Child/adolescent has met admission criteria for the previously approved level of FFT as evidenced by

I.2.1.1 The child/adolescent's symptoms or behaviors persist at a level of severity adequate to meet admission criteria; or

I.2.1.2 The child or youth has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- I.2.1.3 The child/adolescent's symptoms have increased sufficiently over the past 24 hours to warrant immediate increase of number of hours provided weekly to the family, and
- I.2.2 Evidence of active treatment and care management as evidenced by:
 - I.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established, treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly; and
 - I.2.2.2 Child and family (caregiver) participation in treatment is consistent with care plan, or active efforts to engage the patient and/or family are in process. Type, frequency and intensity of services are consistent with treatment plan; and
 - I.2.2.3 Vigorous efforts are being made to affect a timely transition to outpatient care, when such care is consistent with the treatment plan (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments).
 - I.2.2.4 Children receiving FFT services can receive concurrent treatment from other mental health providers including, but not limited to, outpatient, extended day, and partial hospital services if deemed appropriate in the treatment plan.
- I.2.3 If child/adolescent does not meet criterion , continued treatment may still be authorized under any of the following circumstances:
 - I.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through continued home based treatment and such treatment is necessary in order for the discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or
 - I.2.3.2 Child/adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the patient to be discharged directly to a less intensive community-based level of care rather than to a more restrictive setting; or

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

- I.2.3.3 Child/adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including, but not limited to, such resources as placement options, psychiatrist or therapist appointments, therapeutic mentoring, etc). Authorization may be extended based on the individual clinical needs of the child/adolescent. Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with Managed Service System if child is DCF involved or directly with local providers or Community Collaboratives to address aftercare needs).

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

J. OUTPATIENT

Definition

Outpatient therapy services are ambulatory clinical services provided by a general hospital, private freestanding psychiatric hospital, psychiatric outpatient clinic, school based health clinic, state-operated facility, or by a licensed mental health practitioner practicing independently or in a private practice group. This service involves the evaluation, diagnosis, and treatment of individuals, families or groups as well as medication management. Services are typically scheduled in advance, but may occur urgently without a scheduled appointment. Services are provided at a frequency designed to address immediate clinical need as directed by an individual or family treatment plan. Outpatient services are designed to promote, restore, or maintain age appropriate social/emotional functioning and are intended to be focused and time limited with services discontinued as the child/adolescent and family are able to function more effectively.

A child/adolescent can receive services from more than one provider (e.g., clinic, independent practitioner) at any given time offering individual, family, group or medication management services, provided the services are not duplicative. Based on clinical necessity and with review by a care manager, a client may be authorized to receive an outpatient service while simultaneously participating in a higher level of care.

Authorization Process and Time Frame for Service:

This level of care does *not* require prior authorization initially. However, registration *is* required which results in an initial authorization of twenty-six (26) sessions covering a twelve-month period of time. Visits in excess of 26 or those beyond the initial twelve-month period would require prior authorization.

Level of Care Guideline:

J.1.0 Admission Criteria:

- J.1.1 Symptoms and functional impairment include all of the following:
 - J.1.1.1 Diagnosable DSM-IV Axis I or Axis II disorder,
 - J.1.1.2 Symptoms and impairment must be the result of a psychiatric or Substance abuse disorder.
 - J.1.1.3 Functional impairment not solely a result of Mental Retardation, and
 - J.1.1.4 GAF <70

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

J.1.2 Intensity of Service Need

- J.1.2.1 Child/adolescent is experiencing behavioral and/or emotional problems as described in the DSM-IV that can be assessed or safely addressed in an outpatient setting using one or more of the treatment modalities defined above.

J.2.0 Continued Care Criteria

- J.2.1 The child/adolescent has met criteria for outpatient care and there is evidence of active treatment and care management as evidenced by:

- J.2.1.1 Patient and caregiver participation in treatment consistent with care plan, or active efforts to engage the patient and/or caregiver are in process. Type, frequency and intensity of services are consistent with treatment plan, and

- J.2.1.2 A care plan with evaluation and treatment objectives appropriate for this level of care has been established and treatment objectives are related to readiness for discharge, progress towards objectives is being monitored and the patient is making measurable progress but identified objectives have not yet been met.

- J.2.2 If the patient does not meet criteria listed above, additional outpatient services may be authorized if either of the following are true:

- J.2.2.1 There is evidence that the child/adolescent will not be able to maintain functioning without sustained or significant deterioration if treatment is discontinued; or

- J.2.2.2 There is an anticipated stressor within the child's immediate social or family environment that, based on clinical history could reliably predict behavioral and emotional regression (i.e., impending birth of sibling, divorce of parents, scheduled medical procedure, change in home environment, etc.)

- J.2.3 The child/adolescent/family does **not** meet continued care criteria if:

- J.2.3.1 The patient has met treatment goals or the child/adolescent /family has demonstrated minimal or no progress toward treatment goals for a three month period and appropriate modifications of treatment plan have been made and implemented with no significant success, suggesting the

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

child/adolescent/family is not benefiting from outpatient therapy services at this time.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

K. PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING – CHILD

Definition:

Psychological Testing involves the administration and interpretation of standardized tests used to assess an individual's psychological or cognitive functioning. It assists in gaining an understanding of an individual's diagnostic presentation and informs the appropriate course of treatment. Psychological evaluation using various measures may be conducted to clarify a psychiatric diagnosis in situations in which: 1) there is current symptomatic behavior that disrupts functioning and, 2) there is a lack of diagnostic clarity that can not be resolved by standard interview techniques and, 3) this lack of diagnostic clarity is preventing the development or revision of an appropriate treatment plan. Results would be used to determine the best possible treatment approaches, clarify specific client needs, identify client strengths, or distinguish necessary interventions for best clinical utility. Common types of tests are: projective and/or objective personality assessments, intelligence assessments, adaptive living scales, and neuropsychological assessments.

All testing must be done in accordance with the American Psychological Association's Standards for Educational and Psychological Testing. As such, testing must be administered and interpreted by a licensed psychologist and any measure used must have documented standardization, reliability, and evidence that it is appropriate for its intended use and that it enhances diagnostic accuracy. Test results will lead to child specific clinical recommendations that will be shared with caregivers with appropriate release of information as indicated.

Authorization Process and Time Frame for Service:

This service requires prior authorization through the submission of a Request for Psychological Testing form. Requests for psychological testing must target specific diagnostic questions and address the reasons why standard interview techniques or therapies cannot resolve those questions. All children/adolescents referred for psychological or neuropsychological testing and their caregivers may require a preliminary diagnostic interview by the Psychologist scheduled to perform the testing. This interview will allow the Psychologist to identify the specific test instruments needed to address the referral issues.

Once the preliminary diagnostic interview is completed, the psychologist will complete the Request for Psychological Testing Form. Each test and its clinical rationale must be listed. In addition, the time allocation for each test instrument to be used must be estimated based on information from test manufacturers, or, in the absence of such, based on time allotment approved by the Clinical Management Committee. It is expected that certain tests will be scored by computer and additional time for hand scoring will not be authorized. Authorization for this service will be granted not more frequently than once every 12 months unless there is compelling evidence of marked change and 1) there is

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.

substantial clinical reason to suspect organic or trauma related deterioration or 2) previous test results are deemed invalid due to inappropriate administration or 3) client performance was impaired by issues that were unknown to the psychologist at the time of test administration (i.e., child was becoming physically ill, child had recently been traumatized)

Level of Care Guidelines

K.1.0 Admission Criteria

K.1.1 Severity of Symptoms and Functional Impairment

K.1.1.1 The individual has or is believed to have a diagnosable DSM IV Axis I or Axis II disorder, excluding V-codes (neuropsychological testing should be performed for the diagnosis and treatment of an organic disorder,) and

K.1.1.2 Individual evidences significant functional impairment secondary to the above disorder, and

K.1.2 Intensity of Service Need

K.1.2.1 One or more of the following criteria must be met:

K.1.2.1.1 Traditional clinical assessment has not proven effective in identifying the underlying cause for the client's behavioral distress and testing is needed to determine diagnosis and the most appropriate course of treatment; or

K.1.2.1.2 The child/adolescent has not responded to traditional treatment with out a clear explanation of treatment failure and testing is necessary to address issues related to differential diagnosis, and

K.1.2.1.3 The testing will have a timely effect on the revised treatment planning process.

K.1.3 Additional Variables to be Considered:

K.1.3.1 Valid testing was not administered within the last year or there is sufficient justification for repeat/additional testing, and

K.1.3.2 Testing is not routine but medically necessary, and

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- K.1.3.3 Primary purpose of testing is not for educational, vocational, or legal purposes, and
- K.1.3.4 The child/adolescent is not under the influence of alcohol or other substances, undergoing detoxification, or experiencing residual or temporary effects of substance use that are likely to compromise the validity of testing, and
- K.1.3.5 Symptoms of acute psychosis will not interfere with proposed testing validity, and
- K.1.3.6 The time requested for test/test battery does not fall outside of the manufacturer's or the Clinical Management Committee's recommended time frames.

K.2.0 Continued Care Criteria – Not applicable

Note: Making Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases the patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and medical appropriateness and, for anyone under 21, does not meet the EPSDT criteria.