

Louisiana Behavioral Health Partnership Service Authorization Criteria 2012

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Preamble-Principles of Service Authorization Determinations

PRINCIPLES OF SERVICE AUTHORIZATION DETERMINATIONS

Magellan Behavioral Health of Louisiana has the belief that every member is capable of recovery and resiliency. Magellan endeavors to promote care which is increasingly individualized, in which members and their families are empowered to achieve their goals, and in which all members maximize their opportunities to live full lives in their own communities.

Magellan's care managers are available to assist members and their families 24 hours a day and 365 days a year. Providing oversight and support to our care managers are our Care Management Center medical directors and our physician advisors: all Board-certified psychiatrists. This rich resource of psychiatric support allows members to have access to professionals who are knowledgeable about evidence-based practices and are effective in making service authorization determinations.

Magellan is committed to the philosophy of providing treatment at the most appropriate and least restrictive level of care necessary for effective and efficient treatment to meet the member's biopsychosocial needs. We see the continuum of care as a fluid treatment pathway, where members may enter treatment at any level and be moved to more or less intensive levels of care as their changing clinical needs dictate. At any level of care, such treatment should be individualized and should take into consideration the member's stage of readiness to change and participate in treatment.

The Magellan Service Authorization Criteria guide both providers and reviewers to the most appropriate level of care for a member. While these criteria will assign the most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. As in the review of other cases, clinical judgment consistent with the standards of good medical practice will be used in making service authorization determinations.

Service authorization decisions about each member are based on the clinical information provided by the treating practitioner or facility, the application of the service authorization criteria and available treatment resources. We recognize that a full array of services is not available everywhere. When a clinically necessary level of care does not exist or is not available, we will make every attempt to connect the member to an appropriate alternative level of care or service.

Medical Necessity Definition

Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

A. In order to be considered medically necessary, services must be:

- 1) Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction
 - 2) Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the member.
- B. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury being treated and neither more nor less than what the member requires at that specific point in time.
- C. Although a service may be deemed medically necessary, it doesn't mean the service will be covered by the Medicaid program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.

Each criteria set, within each level of care category (see below) is a more detailed elaboration of the above definition for the purposes of establishing service authorization for these health care services. Each set is characterized by admission and continued stay criteria. The admission criteria are further delineated by severity of need and intensity and quality of service.

Particular rules in each criteria set apply in guiding a provider or reviewer to a clinically necessary level of care (please note the possibility and consideration of exceptional member situations described in the preamble when these rules may not apply). For admission, both the severity of need and the intensity and quality of service criteria must be met. The continued stay of a member at a particular level of care requires the continued stay criteria to be met (Note: this often requires that the admission criteria are still fulfilled). Specific rules for the admission and continued stay groupings are noted within the criteria sets.

Levels of Care & Service Definitions

Magellan believes that optimal, high-quality care is best delivered when members receive care that meets their needs in the least-intensive, least-restrictive setting possible. Magellan's philosophy is to endorse care that is safe and effective, and that maximizes the member's independence in daily activity and functioning.

Magellan has defined six levels of care and eleven outpatient and other services as detailed below. These levels of care and services may be further qualified by the distinct needs of certain populations who frequently require behavioral health services. Children, adolescents, and adults often have special concerns not present with mental health disorders alone. In particular, special issues related to family/support system involvement, physical symptoms, medical conditions and social supports may apply. More specific criteria sets in certain of the level of care definitions address these population issues.

The 6 levels of care definitions are:

1. Addiction services

Services include an array of individual-centered outpatient, intensive outpatient and residential/inpatient services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. Services for adolescents must be separate from adult services, be developmentally appropriate, involve the family or caregiver and coordinate with other systems (such as child welfare, juvenile justice and the schools). These services are designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to be barriers to the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals needing more intensive treatment. Outpatient, intensive outpatient and residential/inpatient services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential settings of 16 beds or less, designed to help individuals achieve changes in their substance abuse behaviors.

Addiction services are reviewed utilizing the American Society of Addiction Medicine (ASAM) PPC-2R criteria. These levels of care criteria are found in the ASAM PPC-2R manual, which will be used for authorizing and reviewing addiction services.

2. Hospital (Inpatient), Psychiatric (IP)

IP service is the highest level of skilled psychiatric services provided in a facility. This could be a free-standing psychiatric hospital, or a psychiatric unit of general hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.¹

3. Psychiatric Residential Treatment Facility (PRTF)

Residential Treatment is defined as a 24-hour level of care that provides residential care and services for children and adolescents younger than 21 years of age with long-term or severe mental disorders. This care is medically monitored, with 24-hour medical and nursing services availability. Residential care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs.

PRTF are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the member's situation are assessed and that treatment for those needs is reflected in the Plan of Care (POC) per 42 CFR 441.155. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. In addition to services provided by and in the facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the resident receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the member's situation. The facility must provide treatment meeting State regulations per LAC 48: I. Chapter 90.

Services must meet active treatment requirements, which mean implementation of a professionally developed and supervised individual POC that is developed and implemented no later than 72 hours after admission and designed to achieve the member's discharge from residential status at the earliest possible time. "Individual POC" means a written plan developed for each member to improve his or her condition to the extent that residential care is no longer necessary.

The plan must be reviewed as needed or at a minimum of every thirty days by the facility treatment team to:

- Determine that services being provided are or were required on a residential basis
- Recommend changes in the plan, as indicated by the member's overall adjustment as a resident.

4. Therapeutic Group Homes (TGH)

¹ Louisiana Service authorization criteria do not supersede state or Federal law or regulation concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

TGH provides a community-based residential service in a home-like setting of no greater than eight beds, under the supervision and program oversight of a psychiatrist or psychologist. The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his/her home and community and to regularly attend and participate in work, school or training. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. TGH treatment must target reducing the severity of the BH issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child's or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts). Treatment must:

- Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation
- Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement
- Transition child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy).

The psychiatrist or psychologist must provide 24-hour, on-call coverage seven days a week. The psychologist or psychiatrist must see the member at least once, prescribe the type of care provided, and if the services are not time-limited by the prescription, review the need for continued care every 14 days. Average length of stay ranges from 14 days to six months. TGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range.

5. Therapeutic Foster Care (TFC)

Therapeutic foster care (TFC) services are defined as community-based surrogate family services provided to children living in foster care, who require an intensive period of treatment. TFC services work in partnership with the child, the child's family and other persons identified by the family, Child and Family Team, and placing agency towards the goals outlined in the family's and/or child's plan of care. TFC services allow the child to benefit from a home environment and community-based setting while receiving additional intensive treatment and clinical services, as needed. Children are assessed to need this level of placement through a CANS screening that demonstrates TFC is a sufficient level and regular basic foster care is not a sufficient level. Children in this program are placed in foster families (one or two children per family), whose members are trained and can provide a structured environment in which participants can learn social, and display age appropriate, emotional skills.

6. Non-Medical Group Home (NHGH)

NMGH is a residential setting for up to 16 beds. Children are considered for placement in a NMGH when screened to need this level of care through the Child and Adolescent Needs and Strengths (CANS) criteria. This basic type of placement should be limited to

children whose needs cannot be met in their own home, foster home or children who have reached their treatment goals in a more restrictive setting and are ready to be “stepped down” into a lesser restrictive setting. Services provided in a group home setting must be provided by a community practitioner certified and credentialed by Magellan to provide those services. Children are assessed to need this level of placement through a Coordinated System of Care (CSoC) screening tool that demonstrates NMGH is a sufficient level and regular basic foster care is not a sufficient level. Both the NMGH intervention and other services are decided upon through the Child and Family Team process (or Magellan Care Management where wrap-around services are not available) and Magellan authorization. The NMGH staff is required to participate in the Child and Family Team process. For the child entering placement, group home provides a chance to work on issues in a structured, safe and orderly environment. Group home care presents an opportunity to improve the safety, permanency and well-being of a child through a specialized offering of services that are flexible to meet the particular needs of a child and his or her family or other permanency resource.

The 11 outpatient service definitions are:

1. Assertive Community Treatment (ACT)

ACT services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual’s ability to cope and relate to others and enhancing the highest level of functioning in the community. Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination. The Level of Care Utilization System (LOCUS), psychiatric evaluation and treatment plan will be updated at least every six months, with an additional LOCUS score being completed prior to discharge.

2. Case Conference

A case conference is a scheduled face-to-face meeting between two or more individuals to discuss the member’s treatment. The conference may include treatment staff, collateral contact or the member’s other agency representatives, not including court appearances and/or testimony. Case conference includes communication between a LMHP, advanced practice registered nurse (APRN) or psychiatrist for a member consultation that is medically necessary for the medical management of psychiatric conditions.

3. Community Psychiatric Support and Treatment (CPST)

CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual’s individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family or other

collaterals also may be involved. A minimum of 51 percent of CPST contacts must occur in community locations where the person lives, works, attends school and/or socializes.

Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.

4. Crisis intervention (CI)

CI services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CIs are symptom reduction, stabilization and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes. An episode is defined as the initial face-to-face contact with the individual until the current crisis is resolved, not to exceed 14 days.

5. Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy, more commonly known as "ECT," is a medical treatment performed by highly skilled health professionals including doctors and nurses under the direct supervision of a psychiatrist, who is a medical doctor trained in diagnosing and treating mental illnesses. A course of treatment with ECT usually consists of six to twelve treatments given three times a week for a month or less. The member is given general anesthesia and a muscle relaxant. When these have taken full effect, the member's brain is stimulated, using electrodes placed at precise locations on the member's head, with a brief controlled series of electrical pulses. This stimulus causes a seizure within the brain which lasts for approximately a minute. Because of the muscle relaxants and anesthesia, the member's body does not convulse and the member feels no pain. The member awakens after five to ten minutes, much as he or she would from minor surgery.

6. Family functional therapy (FFT)

FFT services are targeted for youth (aged 10-18) primarily demonstrating externalizing behaviors which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth also may meet criteria for a disruptive behavior disorder attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, also may be accepted as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance abuse issues may be included if they meet the criteria below, and FFT is deemed clinically more appropriate than focused drug and alcohol

treatment. A youth receives FFT for approximately three to four months. During the course of this three-month period, the therapist works with the family in nine to 14, one- to two-hour sessions for less severe cases and up to 26-32, one- to two-hour sessions for youth with more substantial acting-out behaviors.

7. Homebuilders

Homebuilders is an intensive, in-home program providing cognitive behavioral therapy (CBT) through family therapy and parent training for families with children (birth to 18 years of age) demonstrating the following characteristics:

- Antisocial behavior and alienation/delinquent beliefs/general delinquency involvement/drug dealing
- Favorable attitudes toward drug use/early onset of alcohol and other drug use, alcohol and/or drug use
- Early onset of aggression and/or violence
- Victimization and exposure to violence.

The target population is children who are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities. Louisiana also utilizes Homebuilders for children with serious behavior problems at home and/or school. The Homebuilders model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior and family safety. The primary intervention components are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals, using evidence-based cognitive/behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. Families receive four to six weeks of intensive intervention with up to two "booster sessions." Therapists typically serve two families at a time and provide 80 to 100 hours of service, with an average of 45 hours of face-to-face contact with the family.

8. Multi-Systemic therapy (MST)

MST services are targeted for youth 12 to 17 years old. MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth. The duration for MST services is three to six months but, typically no longer than six months. The therapist meets with the youth and family at least weekly but often during a four month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems).

9. Outpatient Therapy

Outpatient treatment is typically individual, family and/or group outpatient psychotherapy, consultative services (including nursing home consultation), mental health assessment, evaluation and testing. Times for provision of these service episodes range from fifteen minutes (e.g., medication checks) to fifty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

10. Psychosocial rehabilitation (PSR)

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. A minimum of 51 percent of a PSR's contacts must occur in community locations where the person lives, works, attends school and/or socializes.

11. Psychological Testing

Consistent with LAC, Title 46, Part LXIII, Chapter 17, Title 46, § 1702, psychological tests are defined as intellectual, personality and emotional, and neurological instruments, which require the administration of a psychologist/medical psychologist or of a qualified technician supervised by a psychologist/medical psychologist (without limiting or restricting the practice of physicians duly licensed to practice medicine by the Board of Medical Examiners). Tests of language, educational and achievement tests, adaptive behavior tests or behavior rating scales, symptom screening checklists or instruments, semi-structured interview tools, and tests of abilities, interests, and aptitude that may be administered by other appropriately licensed or certified professionals are not deemed as psychological tests. Testing may be completed at the onset of treatment to assist in the differential diagnosis and/or help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed and there is no clear explanation for the lack of improvement.

Term Definitions

1. Family:

Individuals identified by an adult as part of his/her family or identified by a legal guardian on behalf of children. Examples include parents/step-parents, children, siblings, extended family members, guardians or other caregivers.

2. Support System:

A network of personal (natural) or professional contacts available to a person for practical, clinical or moral support when needed. Examples of personal or natural contacts would include friends, church, school, work and neighbors. Professional contacts would include primary care physician, psychiatrist, psychotherapist, treatment programs (such as clubhouse, psychiatric rehabilitation), peer specialists and community or state agencies.

3. Significant Improvement:

Services provided at any level of care must reasonably be expected to improve the member's condition in a meaningful and measurable manner. The expectation is that the member can accomplish the following in the current treatment setting:

- a) continue to make measurable progress, as demonstrated by a further reduction in psychiatric symptoms, or
- b) Acquire requisite strengths in order to be discharged or move to a less restrictive level of care.

The treatment must, at a minimum, be designed to alleviate or manage the member's psychiatric symptoms so as to prevent relapse or a move to a more restrictive level of care, while improving or maintaining the member's level of functioning. "Significant improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. This criterion is met when there is a reasonable expectation that if treatment services were withdrawn, the member's condition would deteriorate, relapse further, or require a move to a more restrictive level of care.

For most members, the goal of therapy is restoration to the level of functioning exhibited prior to the onset of the illness. For other psychiatric members, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization may represent maximum benefit of treatment.

4. Suicide attempt:

Term Definitions

Suicide attempt is defined as self-injurious behavior with a nonfatal outcome and evidence that the person intended to die. It does not refer to a “suicide gesture” or parasuicidal behavior in which the aim is not death, but performed for another purpose such as secondary gain or communication of some other need.

5. Recurring suicidal ideation:

Recurring suicidal ideation is having repeated serious thoughts of wanting to take one’s own life, without the suicidal act itself. Recurring suicidal ideation differentiates itself from fleeting, passive or general thoughts of self-harm, which are rejected by the person with no intent of taking action.

6. Self-mutilative behavior:

Intentional self-inflicted damage to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing) requiring medical intervention or treatment, for purposes not socially sanctioned (e.g., body piercing, tattooing, etc.).

7. Telecommunications technology

Telecommunications technology refers to the use of approved transmission of information exchange from one site to another via two-way video and audio electronic communications simultaneously for behavioral health assessment and treatment purposes, including, but not limited to, consultations, office visits, individual psychotherapy and pharmacological management services. Telecommunications treatment cannot be done for the convenience of the provider, but to increase access to behavioral health services for members living in underserved areas. Neither a telephone conversation nor an electronic mail message between a healthcare practitioner and member fulfills this definition.

No videotaping or audio recording of the member examination/evaluation is allowed without the expressed and written consent of the member. In case of emergency certificate issued pursuant to an examination conducted by telemedicine, all requirements listed in Louisiana R.S. 28:53 must be followed. Providers must be credentialed and contracted with Magellan as telecommunications technology providers. All telecommunication technology services must be prior authorized by Magellan.

No person shall practice or attempt to practice medicine across state lines without first complying with the provisions of R.S. 37:1276.1 and without being a holder of either an unrestricted license to practice medicine in Louisiana or a telemedicine license entitling him to practice medicine pursuant to R.S. 37:1276.1.

Levels of Care (Non-outpatient)

Hospitalization (Inpatient), Adult

Criteria for Admission

The specified requirements for severity of illness and intensity of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Illness

Criteria A, B or C (one or more) must be met to satisfy the criteria for severity of illness.

A. Patient presents as a danger to self as evidenced by any of the following:

- 1) A suicide attempt within the past 72 hours *or*
- 2) Documentation that the patient has a current suicide plan, specific suicide intent or recurring suicidal ideation *or*
- 3) Documentation of self-mutilative behavior occurring within the past 72 hours.

B. Patient presents as a danger to others due to a DSM-IV-TR Axis I diagnosis as evidenced by any of the following:

- 1) Dangerously aggressive behavior during the past seven days due to a DSM-IV-TR Axis I diagnosis *or*
- 2) Threats to kill or seriously injure another person with the means to carry out the threat and the threatening behavior is due to a DSM-IV-TR Axis I diagnosis *or*
- 3) Documentation that the patient has a current homicide plan, specific homicidal intent or recurrent homicidal ideation and this is due to a DSM-IV-TR Axis I diagnosis.

C. Patient is gravely disabled and unable to care for self due to a DSM-IV-TR Axis I diagnosis as evidenced by the following:

- 1) Documentation of a serious impairment in function as compared to others of the same age in one or more major life roles (e.g., school, job, family, interpersonal relations, self-care, etc.) due to a DSM-IV-TR Axis I diagnosis *and*
- 2) Presents with acute onset or acute exacerbation of hallucinations, delusions or illusions of such magnitude that the patient's well-being is threatened *or*
- 3) Inability of patient to comply with prescribed psychiatric and/or medical health regimens as evidenced by the following:

- i.* patient has a history of de-compensation without psychotropic medications and patient refuses to use these medications as an outpatient *or*
- ii.* by reason of a serious mental illness impacting rational judgment, patient is at risk of health or life due to non-compliance with medical regimens (e.g., insulin-dependent diabetes, etc.) and patient refuses these medical regimens as an outpatient.

II. Admission - Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. Ambulatory (outpatient) care resources in the community do not meet, and/or do not exist to meet the treatment needs of the patient, or the patient has been unresponsive to treatment at a less intensive level of care.
- B. Services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that the services will no longer be needed by the patient.
- C. Treatment of the patient's psychiatric condition requires services on an inpatient hospital basis, requiring 24-hour nursing observation, under the direction of a psychiatrist, such as, but not limited to:
 - 1) Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others. The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other
 - 2) Active intervention by a psychiatric team to prevent assaultive behavior. The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other
 - 3) The patient exhibits behaviors that indicate that a therapeutic level of medication has not been reached and this necessitates 24-hour observation and medication stabilization. The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other.

III. Admission - Exclusionary

Criteria A, B, C or D (if one or more of the following exists, medical necessity is not met):

- A. Patients with a major medical or surgical illness or injury that would prevent active participation in a psychiatric treatment program. Patients must be medically stable.

- B. Patients with criminal charges who do not have a DSM-IV-TR Axis I diagnosis.
- C. Patients whose anti-social behaviors are a danger to others and those anti-social behaviors are characterological rather than due to a DSM-IV-TR Axis I diagnosis.
- D. Patients who have a DSM-IV-TR Axis II diagnosis of mental retardation without an accompanying DSM-IV-TR Axis I diagnosis.

Criteria for Continued Stay (Extension)

IV. Continued Stay (Extension) – Severity of Illness

Criteria A, B or C (one or more) must be met to satisfy the criteria for continued stay.

- A. Patient presents as a danger to self as evidenced by one or more of the following:
 - 1) Documentation that the patient continues to have a current suicide plan, specific suicide intent, recurring suicidal ideation or suicide attempts
 - 2) Documentation of continuing self-mutilative behavior as a result of a psychiatric disorder.
- B. Patient presents as a danger to others due to a DSM-IV-TR Axis I diagnosis as evidenced by one or more of the following:
 - 1) Documentation that patient continues to display dangerously aggressive behavior due to a DSM-IV-TR Axis I diagnosis *or*
 - 2) Documentation that patient continues to threaten to kill or seriously injure another person with the means, if discharged, to carry out the threat *AND* the threatening behavior is due to a DSM-IV-TR Axis I diagnosis *or*
 - 3) Documentation that the patient continues to have a current homicidal plan, specific homicidal intent, or recurrent homicidal ideation *AND* this is due to a DSM-IV-TR Axis I diagnosis.
- C. Patient is gravely disabled and unable to care for self due to a DSM-IV-TR Axis I diagnosis as evidenced by the following:
 - 1) Documentation of a continuing serious impairment in function as compared to others of the same age in one or more major life roles (e.g., school, job, family, interpersonal relations, self-care, etc.) due to a DSM-IV-TR Axis I diagnosis *and*
 - 2) Documentation that patient continues to present with exacerbation of hallucinations, delusions or illusions of such magnitude that the patient's well-being is threatened *or*

- 3) Documentation of the continuing inability of the patient to comply with prescribed psychiatric and/or medical health regimens as evidenced by one the following:
 - i. patient has a history of de-compensation without psychotropic medications and continues to refuse these medications *or*
 - ii. by reason of a serious mental illness impacting rational judgment, patient is at risk of health or life due to non-compliance with medical regimens (e.g., insulin-dependent diabetes, etc.) and continues to refuse these regimens.

V. Continued Stay (Extension) – Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. Ambulatory (outpatient) care resources in the community do not meet, and/or do not exist to meet the treatment needs of the client, or the patient has been unresponsive to treatment at a less intensive level of care.
- B. Services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that the services will no longer be needed by the member.
- C. Treatment of the patient's psychiatric condition requires services on an inpatient hospital basis, requiring 24-hour nursing observation, under the direction of a psychiatrist, such as but not limited to:
 - 1) Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others. The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other
 - 2) Active intervention by a psychiatric team to prevent assaultive behavior. The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other
 - 3) The patient exhibits behaviors that indicate that a therapeutic level of medication has not been reached and this necessitates 24-hour observation and medication stabilization. The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other.

Hospitalization (Inpatient), Child/Adolescent

Criteria for Admission

The specified requirements for severity of illness and intensity of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Illness

Criteria A, B or C (one or more) must be met to satisfy the criteria for severity of illness.

A. The child is a danger to self (indicator 1, or 2, or 3 and 4 must exist to meet criteria A):

- 1) The child has actually made an attempt to take his/her own life in the last 24 hours. Details of the attempt must be documented *or*
- 2) The child has demonstrated self-mutilative behavior within the past 24-hours. Details of behavior must be documented *or*
- 3) The child has a clear plan to seriously harm him/her self, overt suicidal intent and lethal means available to follow the plan. This information can be from the child or a reliable source. Details of the plan must be documented *and*
- 4) It is the judgment of a mental health professional that the child is at a significant risk of making a suicide attempt without immediate inpatient intervention.

B. Child is a danger to others or property due to a DSM-IV-TR Axis I diagnosis as indicated by: (1, 2 *or* 3 and 4 must exist to meet criteria B. The criteria must arise from a DSM-IV-TR Axis I diagnosis, and include the specific criteria that were met to justify that diagnosis).

- 1) The child has actually engaged in behavior harmful or potentially harmful to others or caused serious damage to property, which would pose a serious threat of injury or harm to others within the last 24-hours. Description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to present *or*
- 2) The child has made threats to kill or seriously injure others or to cause serious damage to property, which would pose a threat of injury or harm to others, and has effective means to carry out the threats. Details of the threats must be documented *or*
- 3) A mental health professional has information from the child or a reliable source that the child has a current plan, specific intent or recurrent thoughts to seriously harm others or property. Details must be documented *and*

- 4) It is the judgment of a mental health professional that the child is at a significant risk of making a homicide attempt or engaging in other seriously aggressive behavior without immediate inpatient intervention.
- C. The child is gravely disabled due to a DSM-IV-TR Axis I diagnosis as indicated by indicators 1 and either 2, 3 or 4 must exist to meet criteria C. The criteria must arise from a DSM-IV-TR Axis I diagnosis and include the specific DSM criteria that justify this diagnosis:
- 1) The child has serious impairment of functioning compared to others of the same age in one or more major life roles (e.g., school, family, interpersonal relations, self-care, etc.) Specific descriptions of the following must be documented:
 - i. deficits in control, cognition or judgment
 - ii. circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance
 - iii. prognostic indicators which predict the effectiveness of inpatient treatment *and*
 - 2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment *or*
 - 3) There is a need for medication therapy or complex diagnostic testing where the child's level of functioning precludes cooperation with treatment in an outpatient or non-hospital based regimen, and may require close supervision of medication and/or forced administration of medication *or*
 - 4) Medical condition co-exists with a DSM-IV-TR Axis I diagnosis which, if not monitored/treated appropriately, places the child's life or well-being at serious risk.

II. Admission - Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for intensity of service.

- A. Services in the community do not exist or do not exist to meet the treatment needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. The services considered, tried and/or needed must be documented.
- B. Services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed by the child.

- C. Treatment of the child's psychiatric condition requires services on an inpatient basis, including 24-hour nursing observation, under the direction of a psychiatrist. The child requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other a basis. These services include, but are not limited to:
- 1) Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others or property
 - 2) Active intervention by a psychiatric team to prevent assaultive behavior
 - 3) 24 hour observation and medication stabilization because the child exhibits behaviors that indicate that a therapeutic level of medication has not been reached.

III. Admission - Exclusionary

Criteria A, B, C, D, E or F (if one or more of the following exists, medical necessity is not met.)

- A. The child has a major medical or surgical illness or injury that prevents active participation in a psychiatric treatment program.
- B. The child has criminal charges pending and does not meet severity of illness and intensity of service criteria.
- C. The child has anti-social behaviors that are a danger to others and does not have a DSM-IV-TR Axis I diagnosis.
- D. The child has a DSM-IV-TR Axis II diagnosis of mental retardation and does not meet severity of illness and intensity of service criteria.
- E. The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria.
- F. The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria.

IV. Continued Stay (Extension) – Severity of Illness

Criteria A, B or C (one or more) must be met to satisfy the criteria for continued stay.

- A. Child is a danger to self. (Indicator 1 or 2 *and* 3 must exist to meet criteria A)
 - 1) Continued documented presence of self-mutilative behavior *or*
 - 2) The child continues to have a clear plan to seriously harm him or herself, overt suicidal intent, and if discharged, lethal means to follow the plan. Details of the

- plan must be documented *and*
- 3) It is the judgment of a mental health professional that the child is still at significant risk of making a suicide attempt without immediate inpatient intervention.
- B. Child is a danger to others or property due to a DSM-IV-TR Axis I diagnosis as indicated by the following. Indicator 1 or 2, or 3 *and* 4 must exist to meet criteria B. The criteria must arise from a DSM-IV-TR Axis I Diagnosis and include the specific criteria that were met in order to justify that diagnosis.
- 1) The child continues to engage in behavior harmful or potentially harmful to others, or cause serious damage to property which would pose a serious threat of injury or harm to others. Description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to present *or*
 - 2) The child continues to make threats to kill or seriously injure others or to cause serious damage to property which would pose a threat of injury or harm to others, and if discharged has effective means to carry out the threats. Details of the threats must be documented *or*
 - 3) A mental health professional has information from the child or a reliable source that the child has a current plan, specific intent or recurrent thoughts to seriously harm others or property. Details must be documented *and*
 - 4) It is the judgment of a mental health professional that the child will engage in other seriously aggressive behavior without immediate inpatient intervention.
- C. Child presents as gravely disabled due to a DSM-IV-TR Axis I diagnosis as indicated by the following. Indicator 1 *and* either 2, 3 or 4 must exist to meet criteria C. The criteria must arise from a DSM-IV-TR Axis I Diagnosis and include the specific criteria that were met in order to justify that diagnosis.
- 1) The child continues to have serious impairment of functioning compared to others of the same age in one or more major life roles (e.g., school, family, interpersonal relations, self-care, etc.) Specific description of the following must be documented:
 - i. deficits in control, cognition, or judgment
 - ii. circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance
 - iii. prognostic indicators which predict the effectiveness of acute treatment *and*
 - 2) The acute onset of psychosis or severe thought disorganization or clinical

deterioration continues to render the child unmanageable and unable to cooperate in non-hospital treatment *or*

- 3) There is a continued need for medication therapy or complex diagnostic testing where the child's level of functioning precludes cooperation with treatment in an outpatient or non-hospital based regimen, and may require close supervision and/or involve forced administration of medication *or*
- 4) A medical condition continues to co-exist with a DSM-IV-TR Axis I diagnosis which, if not monitored/treated appropriately, places the child's life or well-being at serious risk.

V. Continued Stay (Extension) – Intensity of Service

Criteria A, B and C must be met to satisfy the criteria for continued stay.

- A. Services in the community do not exist and/or do not meet the treatment needs of the child or the child has been unresponsive to treatment at a less intensive level of care. Services considered and rationale must be documented.
- B. Services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed by the child.
- C. Treatment of the child's psychiatric condition requires services on an inpatient basis, including 24-hour nursing observation, under the direction of a psychiatrist. The child requiring this treatment must not be on independent passes or unit passes without observation or accompaniment by hospital personnel or a responsible other. These services include but are not limited to:
 - 1) suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others or property
 - 2) active intervention by a psychiatric team to prevent assaultive behavior
 - 3) twenty-four hour observation and medication stabilization because the child exhibits behaviors that indicate that a therapeutic level of medication has not been reached.

Psychiatric Residential Treatment Facility (PRTF), Child/Adolescent

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A, B, C, D, E and F must be met:

- A. Ambulatory care resources available in the community do not meet the treatment needs of the member.
- B. There is a high potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.
- C. Proper treatment of the member's psychiatric condition requires services on a residential basis under the direction of a physician.
- D. Either:
 - 1) There is clinical evidence that the member would be at risk to self or others if he or she were not in a residential treatment program *or*
 - 2) As a result of the member's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential harm to self.
- E. The services can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed.
- F. The member is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D and E must be met

- A. A professionally developed and supervised individual plan of care (POC) that is developed and implemented no later than 72 hours after admission and designed to achieve the member's discharge from residential status at the earliest possible time.

- B. The plan must be reviewed as needed or at a minimum of every thirty days by the facility treatment team to:
 - 1) Determine that services being provided are or were required on a residential basis
 - 2) Recommend changes in the plan, as indicated by the member's overall adjustment as a resident.

- C. The facility treatment team develops and reviews the individual POC. The individual POC must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, residents in the facility. The individual POC must be developed by a team of professionals who have the education and experience, preferably including competence in child psychiatry. The POC must:
 - 1) Be based on a diagnostic evaluation conducted within the first 24 hours of admission
 - 2) Be developed by a team of professionals in consultation with the child and the parent, legal guardian or others in whose care the child will be released after discharge
 - 3) State treatment objectives
 - 4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives
 - 5) Include post-discharge plans and coordination of residential services, with partial discharge plans and related community services to ensure continuity of care upon discharge.

- D. Children/adolescents must have access to education services, including supports to attend school if possible, or in-house educational/vocational components if serving adolescents.

- E. For milieu management, the program should incorporate some form of research-based, trauma informed programming and training, if the primary research-based treatment model used by the program does not.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met:

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

- 1) The persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs) *or*
 - 2) The emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs) *or*
 - 3) That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment.
- B. There is evidence of objective, measurable and time-limited therapeutic clinical goals that must be met before the member can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the member's ability to return to a less-intensive level of care.
- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in weekly progress notes, written and signed by the provider.
- E. There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Therapeutic Group Home, Child/Adolescent

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A and B must be met.

- A. Less intensive levels of treatment must have been determined to be unsafe, unsuccessful or unavailable.
- B. The child or adolescent must require active treatment that would not be able to be provided at a less restrictive level of care being provided on a 24-hour basis with direct supervision/ oversight by professional behavioral health staff that would not be able to be provided at a less restrictive level of care.

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D, E, F, G and H must be met.

- A. Screening and assessment is required upon admission, and every 14 days thereafter, to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues.
- B. The setting must be geographically situated to allow ongoing participation of the child's family.
- C. The child or adolescent must attend a school in the community (e.g., a school integrated with children not from the group home and not on the group home's campus).
- D. In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.
- E. The TGH is required to coordinate with the child's or adolescent's community resources, including schools, with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

- F. For milieu management, all programs also should incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not.
- G. Discharge planning begins upon admission, with concrete plans for the child to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan.
- H. The treatment plan must include behaviorally measurable discharge goals.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met:

- A. The child or adolescent continues to meet admission criteria.
- B. The child or adolescent is making adequate improvement. Transition should occur to a more appropriate level of care, if child is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care.
- C. The child or adolescent, and family as appropriate, are making progress toward goals and actively participating in the interventions.
- D. The reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.

Therapeutic Foster Care, Child/Adolescent

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A and B must be met:

- A. Less intensive levels of treatment must have been determined to be unsafe, unsuccessful or unavailable.
- B. The child or adolescent must require active treatment that would not be able to be provided at a less restrictive level of care being provided on a 24-hour basis with direct supervision/ oversight by professional behavioral health staff that would not be able to be provided at a less restrictive level of care.
- C. The child or adolescent has been determined to need this level of placement based on CANS results that demonstrates TFC is a sufficient level and regular basic foster care is not a sufficient level. If the CANS results indicate a lower level is more appropriate, clinical justification for this level of care needs to be demonstrated.

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D and E must be met:

- A. The primary goal of TFC service is to decrease problem behavior and to increase developmentally appropriate normative and pro-social behavior in children and adolescents who are in need of out-of-home placement in order to facilitate a permanent placement or less restrictive family placement upon discharge from TFC.
- B. TFC services work in partnership with the child, the child's family and other persons identified by the family, Child and Family Team, and placing agency towards the goals outlined in the family's and/or child's plan of care.
- C. Children in this program are placed in foster families (one or two children per family), whose members are trained and can provide a structured environment in which participants can learn social, and display age appropriate, emotional skills.
- D. TFC treatment goals are accomplished by providing children whose special needs can be met in a therapeutic family setting, with close supervision, fair and consistent limits,

predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult and reduced exposure to peers with similar problems.

- E. TFC services are a blend of natural and community supports, TFC agency provided services, department provided services and Medicaid provided services. Both the TFC Intervention and other Services are decided upon through the Child and Family Team process.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met:

- A. The child or adolescent continues to meet Admission Criteria.
- B. The child or adolescent is making adequate improvement. Transition should occur to a more appropriate level of care if the child is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care.
- C. The child or adolescent, and family as appropriate, are making progress toward goals and actively participating in the interventions.
- D. The reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.

Non-Medical Group Home (NMGH), Child/Adolescent

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A and B must be met:

- A. Limited to a child or adolescent whose needs cannot be met in their own home, foster home or child/adolescent who has reached his or her treatment goals in a more restrictive setting and is ready to be “stepped down” into a less restrictive setting.
- B. The child or adolescent is assessed to need this level of placement through the results of a CANS evaluation that demonstrates NMGH is a sufficient level and lower level of care is not. If the CANS results indicate a lower level is more appropriate, clinical justification for this level of care needs to be demonstrated.

II. Admission – Intensity and Quality of Service

Criteria A through N must be met. For group home diagnostic centers/step-down criteria O through R also must be met. For mothers with infant group home criteria S through Z must be met (in addition to A through N).

- A. Both the NMGH intervention and other services are decided upon through the Child and Family Team process (or Magellan Care Management where wrap-around services are not available) and Magellan authorization.
- B. The NMGH staff is required to participate in the Child and Family Team process.
- C. The setting presents an opportunity to improve the safety, permanency and well-being of a child through a specialized offering of services that are flexible to meet the particular needs of a child and his or her family or other permanency resource.
- D. The facility provides an environment where treatment can be effective, but no treatment is provided by facility staff. Milieu for this level of care includes reinforcement of skill building taught in treatment.
- E. The NMGH will coordinate and provide transportation and linkages to community network providers for behavioral health treatment of residents.

- F. The NMGH will coordinate and provide transportation and linkages to community network providers for physical health treatment of residents.
- G. The NMGH ensures that Crisis intervention (CI) is obtained, as needed.
- H. Children living in the NMGH attend school in public school system.
- I. Staff has special training in working with at-risk children and in CI strategies and provides 24-hour supervision.
- J. Services provided by community providers enrolled with Magellan within the residential setting shall be individualized, strength-based and culturally competent and guided by a service planning team that includes residential staff, community providers, natural supports, child and family (e.g., extended family, birth family, adoptive family, etc.) as appropriate.
- K. Goals in the service plan and services offered shall support timely movement through the continuum and Department of Children and Family Service (DCFS) permanency goals for the child.
- L. The NMGH shall support child's relationship with family through allowing in-person visits in the facility or contact via phone, mail, email, etc. or by providing the child transportation to attend scheduled visits with family members in accordance with the child's case plan.
- M. The NMGH shall provide education and support to the child's parent(s) to develop parental capacity and to prepare them for resuming care of the child, as applicable, and as planned through the planning process.
- N. The NMGH shall collaborate with providers of other services in the continuum, as well as community providers, to ensure transition through the continuum and linkage to community services to support permanency goals.
- O. The diagnostic centers shall be used to provide intensive, short-term placement for children with a specific goal of a complete assessment of the child's and family's needs.
- P. The diagnostic center will coordinate and provide transportation and linkages to community providers enrolled with the Magellan for the full array of assessments needed for behavioral health, medical, social and developmental needs of residents.
- Q. The placement shall not exceed 60 days.
- R. Discharge planning shall begin at admission to ensure transition of the child prior to

the 60-day timeline. A discharge summary will be completed within 14 days for planned discharges or, immediately, for unplanned discharges.

- S. This program provides a living arrangement for pregnant teenagers, which allows the young mother and her infant to remain in the placement after the birth of her child.
- T. The program assists with care for the infant during the hours that the young mother is attending an educational/vocational program, developing her skills in parenting and preparing for independent living with the assistance of the provider.
- U. Ensure that the mother receives routine and emergency medical care, including pre-natal and post-natal care.
- V. Provide assistance to the mother in arranging child care and other needed services for the infant.
- W. Ensure that community providers provide group or individual counseling regarding decision making for the mother and her infant, responsibilities of parenthood and conflict resolution.
- X. Transition planning to a permanent living arrangement for the child and baby shall begin within three months following the birth of the child.
- Y. Provider shall not be responsible for providing direct care services to the non-custody infant, other than supervision. Providers are responsible for ensuring that adequate care of infants is provided by their mother.
- Z. Transportation services are allowable, if the mother is present.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met:

- A. The child or adolescent continues to meet admission criteria.
- B. Participate in the Office of Juvenile Justice (OJJ) service planning conference, DCFS family team conferences or Wraparound Agency: Child and Family Team (WAA CFT) to plan for the child and support the permanency goal of the child.
- C. The child or adolescent, and family is appropriate, are making progress toward goals and actively participating in the interventions.

- D. The reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.

Outpatient and Other Services

Assertive Community Treatment (ACT)

Criteria for Admission

The specific requirements for severity of need *and* intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A, B, C, D and E must be met:

- A. Meets functional assessment criteria for target population under the 1915(i) for Medicaid individuals 18 years of age and older.
- B. The individual must have one of the following primary diagnoses (secondary diagnosis of substance abuse disorder, *or* developmental disability are not an exclusion):
 - 1) Schizophrenia
 - 2) Bipolar disorder
 - 3) Major depressive disorder
 - 4) Other psychotic disorder *and*
- C. One or more of the following service needs present:
 - 1) Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months
 - 2) Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life
 - 3) Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance abuse [this includes involuntary commitment, ACT/forensic assertive community treatment (FACT)]
 - 4) Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided
 - 5) One or more incarcerations in the past year related to mental illness and/or substance abuse (FACT)
 - 6) Psychiatric and judicial determination that (FACT) services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT)

Assertive Community Treatment (ACT)

- 7) Recommendations by probation and parole, or a judge with a (FACT) screening interview, indicating services are necessary to prevent probation/parole violation (FACT) *and*

D. Meets at least one of the following:

- 1) Inability to participate or remain engaged or respond to traditional community-based services
- 2) Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless
- 3) Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT) *and*

E. Meets at least three of the following:

- 1) Evidence of co-existing mental illness and substance abuse/dependence
- 2) Significant suicidal ideation, with a plan and ability to carry out within the last two years
- 3) Suicide attempt in the last two years
- 4) History of violence due to untreated mental illness/substance abuse within the last two years
- 5) Lack of support systems
- 6) History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability
- 7) Threats of harm to others in the past two years
- 8) History of significant psychotic symptomatology, such as command hallucinations to harm others
- 9) Global assessment of functioning of 50 or less.

II. Admission – Intensity and Quality of Service

Criteria A, B, C and D must be met:

- A. Provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with persons with severe and persistent mental illness (SPMI).
- B. An ACT program directly provides the following supports and services:

Assertive Community Treatment (ACT)

- 1) Availability of service 24 hours a day, seven days a week
- 2) Services are both individual-directed and recovery-oriented
- 3) Needs assessment and individual care plan development
- 4) Crisis assessment and intervention
- 5) Symptom management and mediation
- 6) Individual counseling with individualized service plan and supports are developed
- 7) Medication administration, monitoring, education and documentation
- 8) At least 90 percent of services are delivered as community-based outreach services
- 9) Skills training in activities related to self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities
- 10) Social skills training necessary for functioning in a work, educational, leisure or other community environment
- 11) Peer support
- 12) Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management
- 13) Referral and linkage or direct assistance to ensure that individuals obtain the basic necessities of daily life, including medical, social and financial supports
- 14) Education, support and consultation to individuals' families and other major supports
- 15) Assistance in applying for benefits (includes Social Security Income, Medicaid and Patient Assistance Program enrollment)
- 16) For those clients with forensic involvement, the team will liaise with the forensic coordinators, providing advocacy, education and linkage with the criminal justice system to ensure the individual's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.

Assertive Community Treatment (ACT)

- C. Program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and has gradual expectations for abstinence.
- D. Provide a minimum of six encounters with the service member or collateral contact monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must all be met:

- A. Clinical evidence indicates a persistence of the problems that necessitated the provision of treatment services and there is broad and persistent effect on the individual's ability to effectively manage day-to-day activities of living and self support on an independent basis.
- B. There is a reasonable expectation that the individual will benefit from the ACT program. As measured by an observable positive or beneficial response to treatment, including, but not limited to, medication adherence, homework assignments and collaborating with the ACT team in treatment.
- C. Individual is making attempt/progress toward goals and is benefiting from the plan of care, as evidenced by attainment of therapeutic rapport, lessening of symptoms over time, and stabilization of psychosocial functioning through service planning, homework and team involvement.
- D. Treatment promotes individual self-efficiency and maximizes independent functioning. Employment of treatment techniques encourages use of natural support systems to promote an individual's mastery of his or her environment.
- E. Service provision for ACT will be based on comprehensive history and ongoing assessment (which includes items related to court orders, identified within 30 days of admission and updated every 90 days or as new court orders are received):
 - 1) Psychiatric history, status and diagnosis
 - 2) Level of Care Utilization System (LOCUS), updated every six months and prior to discharge
 - 3) Psychiatric evaluation and individualized treatment plan updated every six months
 - 4) Telesage Outcomes Measurement System, as appropriate
 - 5) Housing and living situation

Assertive Community Treatment (ACT)

- 6) Vocational, educational and social interests and capacities
 - 7) Self-care abilities
 - 8) Family and social relationships
 - 9) Family education and support needs
 - 10) Physical health
 - 11) Alcohol and drug use
 - 12) Legal situation
 - 13) Personal and environment resources.
- F. Monitoring and follow-up to help determine if psychiatric, substance abuse, mental health support and health related services are being delivered, as set forth in the care plan, adequacy of services in the plan and changes, needs or status of individual.

Case Conference, Adult and Child/Adolescent

I. Severity of Need

Criteria A and B must be met to satisfy the criteria for severity of need.

- A. Children functionally eligible for CSoC and adults eligible for 1915(i)
- B. Services are necessary for the medical management of psychiatric conditions

II. Intensity and Quality of Service

For adults, Criteria A, B, and C must be met to satisfy the criteria for intensity and quality of service. For children/adolescents, Criteria A, B, C and D must be met.

- A. Services are face-to-face. Case conference includes communication between a LMHP, APRN, or psychiatrist for a member consultation for the medical management of psychiatric conditions.
- B. Case Conference does not duplicate any other Medicaid State Plan service or service otherwise available to member at no cost.
- C. Coordination with other medical professionals to support the provision of the case conference, as needed.
- D. For children/adolescents, there must be coordination and communication with the family and/or legal guardian, including any agency legally responsible for the care or custody of the member.

III. Exclusion Criteria

Case Conference will not be authorized under the following conditions:

- A. Time spent on telephonic coordination
- B. Court appearances and/or testimony

Community Psychiatric Support and Treatment (CPST), Adult and Child/Adolescent

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A (adults only), B, C and D must be met:

- A. Meets functional assessment criteria for target population under the 1915(i) for individuals 21 and older; or older than 18 years of age for 1915(i) only individuals.
- B. The member is unable to maintain an adequate level of functioning without this service due to a mental health disorder as evidenced by (must meet 1 and either 2 or 3):
 - 1) Severe symptoms and/or history of severe symptoms for a significant duration *and*
 - 2) Inability to perform the activities of daily living *and/or*
 - 3) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.
- C. The member seeks and actively participates in a joint provider/member assessment and the provider/member jointly agree that the member desires, is committed to, will likely benefit from the supportive/rehabilitation process.
- D. The interventions necessary to reverse, stabilize or enhance the member's condition requires the frequency, intensity and duration of contact provided by the CPST provider as evidenced by:
 - 1) Failure to reverse/stabilize/progress with a less intensive intervention *and/or*
 - 2) Need for specialized intervention for a specific impairment or disability.

II. Admission – Intensity and Quality of Service

Criteria A, B, C and D, *and* either E or F must be met for adults. Criteria A, B, C, D, G and H must be met for children and adolescents.

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of

minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

- B. Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis to the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains and to adapt to community living.
- C. Participation in and utilization of, strengths-based planning and treatments, which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk him or her remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.
- E. Restore, rehabilitate and support the individual to develop skills to locate, rent and keep a home, negotiate with a landlord, select a roommate and understand renter's rights and responsibilities.
- F. Assist the individual to develop daily living skills specific to managing his or her own home to include managing their money, medications and using community resources and other self care requirements.
- G. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- H. School-based health services include covered BH services, treatment and other measures to correct or ameliorate an identified mental health or substance abuse diagnosis. Services are provided by or through a Local Education Agency (LEA) to children with, or suspected of having, disabilities who attend school in Louisiana.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met:

Community Psychiatric Support and Treatment (CPST), Adult and Child/Adolescent

- A. The member continues to meet admission criteria.
- B. Recovery requires a continuation of these services.
- C. Member, and family as appropriate, are making progress toward goals and actively participating in the interventions.
- D. There is a reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.

Crisis Intervention, Psychiatric

Criteria for Admission

An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis, and this will not, in and of itself, disqualify them for eligibility for the service. Crisis Intervention is authorized up to six hours per episode and is not subject to Service authorization Criteria review.

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A, B and C must be met:

- A. Must have a valid principal DSM-IV TR Axis I or II diagnosis *and*
- B. All individuals who self-identify as experiencing a seriously acute psychological/emotional change, which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible *and*
- C. Either:
 - 1) Meets functional assessment criteria for target population under the 1915(i) State Plan for individuals older than 18 years of age *or*
 - 2) Meets medical necessity criteria (MNC) for rehabilitation services for children younger than 21 years of age.

II. Admission – Intensity and Quality of Service

Criteria A and B must be met:

- A. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services includes but is not limited to the following:
 - 1) Contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment *and/or*

- 2) Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care *and/ or*
 - 3) Referral to other alternative mental health services at an appropriate level may be considered.
- B. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.

Criteria for Continued Stay

III. Continued Stay

Criteria A and B must be met:

- A. The member continues to meet admission criteria
- B. Despite reasonable therapeutic efforts, the clinical evidence indicates the need for at least one of the following:
 - 1) Short-term Crisis Intervention, including crisis resolution and debriefing with the identified Medicaid-eligible individual *or*
 - 2) Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members *or*
 - 3) Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.

Electroconvulsive Therapy (Outpatient)

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive therapy is considered a treatment of “last resort”.

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.^{DD1}
- B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient’s medical status, the treatment history and the patient’s preference regarding treatment should be considered.
- C. One of the following:
 - 1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*
 - 2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*
 - 3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*
 - 4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.
- D. The patient’s status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation,

severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. All:

- 1) the patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *and*
- 2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course, *and*
- 3) the patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F, G and H must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:

- 1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*
- 2) medical history and examination focusing on neurological, cardiovascular, and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT; *and*

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:

- 1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*
- 2) required modifications in medications or standard anesthetic technique, if any.

Electroconvulsive Therapy (Outpatient)

- C. There is documentation of extra precautions taken for ECT in pregnant women, including the addition of obstetrician to the psychiatrist and anesthesiologist team, appropriate obstetrical evaluation, close coordination with obstetrical provider, and that fetal monitoring appropriate for gestational age is utilized in the time period surrounding ECT therapy in pregnant women. Such documentation should also include evaluation of need for inpatient treatment (or extended outpatient evaluation) for women in third trimester of pregnancy for fetal evaluation during and after ECT.
- D. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions that addresses:
 - 1) specific medications to be administered during ECT, *and*
 - 2) choice of electrode placement during ECT, *and*
 - 3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- E. There is continuous physiologic monitoring during ECT treatment, addressing:
 - 1) seizure duration, including missed, brief, and/or prolonged seizures, *and*
 - 2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*
 - 3) electrocardiographic activity, *and*
 - 4) vital signs, *and*
 - 5) oximetry, *and*
 - 6) other monitoring specific to the needs of the patient.
- F. There is monitoring for and management of adverse effects during the procedure, including:
 - 1) cardiovascular effects, *and*
 - 2) prolonged seizures, *and*
 - 3) respiratory effects, including prolonged apnea, *and*
 - 4) headache, muscle soreness, and nausea.
- G. There are post-ECT stabilization and recovery services, including:
 - 1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*

Electroconvulsive Therapy (Outpatient)

- 2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.
- H. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
- 1) the persistence of problems that meet the outpatient electroconvulsive therapy Severity of Need criteria as outlined in I; *or*
 - 2) the emergence of additional problems that meet the outpatient electroconvulsive therapy Severity of Need criteria as outlined in I; *or*
 - 3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.
- B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
- C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Electroconvulsive Therapy (Inpatient)

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT). Nothing in the criteria should suggest that electroconvulsive therapy is considered a treatment of “last resort”.

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.^{DD1}
- B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient’s medical status, the treatment history and the patient’s preference regarding treatment should be considered.
- C. One of the following:
 - 1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*
 - 2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*
 - 3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*
 - 4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

- D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.
- E. All:
 - 1) the patient is medically stable and requires the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *or*
 - 2) the patient does not have access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.
- F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

- A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:
 - 1) psychiatric history, including documented past response to ECT, mental status and current functioning; *and*
 - 2) medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.
- B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
 - 1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*
 - 2) required modifications in medications or standard anesthetic technique, if any.
- C. There is documentation of extra precautions taken for ECT in pregnant women, including the addition of obstetrician to the psychiatrist and anesthesiologist team,

appropriate obstetrical evaluation, close coordination with obstetrical provider, and that fetal monitoring appropriate for gestational age is utilized in the time period surrounding ECT therapy in pregnant women. Such documentation should also include evaluation of need for inpatient treatment (or extended outpatient evaluation) for women in third trimester of pregnancy for fetal evaluation during and after ECT.

- D. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions that addresses:
- 1) specific medications to be administered during ECT, *and*
 - 2) choice of electrode placement during ECT, *and*
 - 3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- E. There is continuous physiologic monitoring during ECT treatment, addressing:
- 1) seizure duration, including missed, brief and/or prolonged seizures, *and*
 - 2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*
 - 3) electrocardiographic activity, *and*
 - 4) vital signs, *and*
 - 5) oximetry, *and*
 - 6) other monitoring specific to the needs of the patient.
- F. There is monitoring for and management of adverse effects during the procedure, including:
- 1) cardiovascular effects, *and*
 - 2) prolonged seizures, *and*
 - 3) respiratory effects, including prolonged apnea, *and*
 - 4) headache, muscle soreness and nausea.
- G. There are post-ECT stabilization and recovery services, including:
- 1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*
 - 2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular

Electroconvulsive Therapy (Inpatient)

disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
 - 1) the persistence of problems that meet the inpatient electroconvulsive therapy Severity of Need criteria as outlined in I.; *or*
 - 2) the emergence of additional problems that meet the inpatient electroconvulsive therapy Severity of Need criteria as outlined in I; *or*
 - 3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.
- B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
- C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Family Functional Therapy (FFT)

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission of youth defined as between 10 to 18 years of age.

I. Admission – Severity of Need

Criteria A, B, C and D must be met:

- A. Externalizing behaviors symptomatology which adversely affects family functioning or functioning in other systems, resulting in a DSM-IV-TR diagnosis of conduct disorder or other diagnoses consistent with such symptomatology.
- B. Referred by other service providers and agencies on behalf of the youth and family, though other referral sources also are appropriate.
- C. At least one adult caregiver is available to provide support and is willing to be involved in treatment.
- D. Youth's interagency service planning team recommends that he/she participate in FFT.

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D and E must be met:

- A. Provide a range of 14-32 one- to two-hour FFT sessions in the family's home or community for an expected duration of three to four months.
- B. FFT must work with any treatment planning team to develop an individualized treatment plan.
- C. FFT treatment is attuned to the importance of ethnicity and culture for all clients referred for services.
- D. By maintaining the youth within the community in the least restrictive environment, FFT treatment interventions strengthen the family and youth's relationship with community resources and the people managing them which are consistent with the Child and Adolescent Services System Program principles.
- E. FFT's requirements for measuring individual outcome include the following four domains of assessment used to monitor progress towards goals:

Family Functional Therapy (FFT)

- 1) Member assessment (use of outcome questionnaire family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment)
- 2) Adherence assessment (use of the counseling process questionnaire and clinical services system tracking/adherence reports, global therapist ratings)
- 3) Outcome assessment (use of the therapist outcome measure, counseling outcome measure parent/adolescent and post-assessment outcome questionnaire family measures and post-risk and protective factors assessment)
- 4) Case monitoring and tracking (member service system reports).

III. Exclusion Criteria

Criteria A must be met to exclude individual from FFT services.

- A. Youth has a functional impairment as a result of pervasive developmental disorder or intellectual disability.

Criteria for Continued Stay

IV. Continued Stay

Criteria A, B, C and D must be met:

- A. Severity of symptoms (at least one of the following)
 - 1) The youth and family are making progress toward goals, and the treatment team review recommends continued stay *or*
 - 2) The presenting conditions, symptoms or behavior continue such that family and natural community supports alone are insufficient to stabilize the youth's condition *or*
 - 3) The appearance of new conditions, symptoms or behavior meeting the admission criteria.
- B. There must be family commitment to the treatment process of the youth. The treatment must support community integrative objectives including development of the youth's network of personal, family and community support.
- C. The youth and family are unable to demonstrate their ability to utilize resources within the community.
- D. There is a reasonable expectation that the youth and/or family will benefit with the continuation of services.

Homebuilders

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission for families with children (birth to 18 years of age).

I. Admission – Severity of Need

Criteria A, B, C or D (at least one) must be met:

- A. Children returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities, with at least one or more of the following:
 - 1) Family functioning issues
 - 2) Trauma exposure
 - 3) Academic failure
 - 4) Incurability
 - 5) Academic problems
 - 6) Delinquency.
- B. Children with serious behavior problems at home and/or school with at least one of the following:
 - 1) Non-compliance with parental or school rules
 - 2) Fighting (physical and verbal)
 - 3) Serious tantrums, and acting out behaviors
 - 4) Behaviors related to other conditions such as ADHD, oppositional defiant disorder, anxiety, mood disorders, reactive attachment disorders, etc.
 - 5) Withdrawn behaviors (depression) and suicidal behaviors.
- C. Any child who is at risk of psychiatric or residential placement or about to move to a more restrictive environment due to their behavioral/emotional problems

- D. Child is transitioning from a more restrictive to a less restrictive placement "step-down" service (such as a move from a group home to foster home or relative).

II. Admission – Intensity and Quality of Service

Criteria A, B and C must be met:

- A. Provide services for four to six weeks of intensive intervention with up to two “booster sessions”.
- B. Services are strengths-based and goals are aimed at effective parenting, improved family environment, improved child/adolescent behavior, and pro-social family involvement.
- C. Treatment provides the following support and services within the family’s home and community:
 - 1) Availability of services for Crisis Intervention 24 hours a day, seven days a week
 - 2) Completes collaboratively with each family an assessment of family strengths, problems and barriers to service/treatment and outcome-based goals and treatment plans
 - 3) Employ research-based treatment practices such as motivational interviewing, behavioral parent training, CBT strategies and relapse prevention
 - 4) Identification of formal and informal support system, develop and enhance supports and resources for maintaining and facilitating changes.

Criteria for Exclusion

III. Exclusion

Criteria A, B or C (any one of the following) must be met:

- A. Family/child’s identified problem is primarily social, financial and/or medical (non-psychiatric) in the absence of a primary behavioral problem as defined in the admission criteria.
- B. Family/child is simultaneously receiving similar services of equal or greater intensity via another resource.
- C. Treatment is for autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability or mental retardation.

Criteria for Continued Stay

IV. Continued Stay

Criteria A through D and either E or F must be met:

- A. Family/child and services continue to meet the admission criteria defined above.
- B. There is reasonable expectation that the family/child will benefit for the continuation of the services.
- C. Treatment promotes developmentally appropriate behavior, activities, skills and social skills for the child in his/her natural context through focusing on his or her individual strengths and needs.
- D. Interventions are employed in the treatment plan that are time limited in nature and subordinate to a goal of enhanced autonomy and family functioning.
- E. Appearance of new problems or symptoms which meet admission criteria.
- F. The child requires the continuation of a treatment while in the community until an effective family and community support network can be activated.

Multi-Systemic Therapy (MST)

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission of youth defined as between 12 to 17 years of age. MST services may not be clinically appropriate for individuals who meet criteria for out-of-home placement due to suicidal, homicidal or psychotic behavior; youth living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers; the referral problem is limited to serious sexual misbehavior; youth has a primary diagnosis of autism spectrum disorder or mental retardation; low-level need cases; or youth who have previously received MST services or other intensive family- and community-based treatment (except when specific conditions have been identified that have changed in the youth's ecology, compared to the first course of treatment).

I. Admission – Severity of Need

Criteria A, or B, or C (at least one) *and* D, E, F and G must be met:

- A. The youth's treatment planning team or child and family team (CFT) recommends that he or she participate in MST *or*
- B. Youth with depression and other disorders when the existing mental and behavioral health issues manifest in outward behaviors that impact multiple systems (e.g., family, school, community) *or*
- C. Youth with substance abuse issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment *and*
- D. Externalizing behaviors symptomatology such as chronic or violent juvenile offenses, resulting in a DSM-IV (Axis I) diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (e.g., octachlorodibenzo-p-dioxin, behavioral disorder not otherwise specified, etc.)
- E. Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting
- F. Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems
- G. Less intensive treatment has been ineffective or is inappropriate.

II. Admission – Intensity and Quality of Service

Criteria A, B, C, D and E all must be met:

Multi-Systemic Therapy (MST)

- A. Provide practical and goal-oriented treatment that specifically targets the factors in a youth's social network that are contributing to the problem behaviors.
- B. Provide at least weekly encounters with the youth or family for an expected duration of service of three to six months.
- C. MST treatment directly provides the following support and services within the family's home or community:
 - 1) Availability of services 24 hours a day, seven days a week
 - 2) Assessment and ongoing treatment planning based the specific behavior
 - 3) Family therapy
 - 4) Individual therapy (not the primary mode of treatment and is not provided to caregivers or family members)
 - 5) Parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals)
 - 6) Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors
 - 7) Referral for psychological assessment, psychiatric evaluation and medication management if needed.
- D. MST treatment is attuned to the importance of ethnicity and culture for all clients referred for services.
- E. By maintaining the youth within the community in the least restrictive environment, MST treatment interventions strengthen the family and youth's relationship with community resources and the people managing them.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must all be met:

- A. Treatment does not require more intensive level of care.
- B. The treatment plan has been developed, implemented and updated based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.

Multi-Systemic Therapy (MST)

- C. Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.
- D. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Outpatient Treatment, Psychiatric, Adult and Child/Adolescent

Criteria for Treatment Status Review

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for the treatment review. Includes hospital outpatient services and other licensed practitioner outpatient therapy and applicable for individual, family, and group treatment.

I. Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The member has, or is being evaluated for, a DSM-IV-TR diagnosis on Axis I.
- B. The presenting behavioral, psychological, and/or biological dysfunctions and functional impairment (occupational, academic, social) are consistent and associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I.
- C. One of the following:
 - 1) The member has at least mild symptomatic distress and demonstrates impaired functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, scholastic, or social), that are the direct result of an Axis I disorder. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas consistent with a global assessment of functioning (GAF) (DSM-IV-TR Axis V) score of less than 71 *or*
 - 2) The member has a persistent illness described in DSM-IV-TR with a history of repeated admissions to 24-hour treatment programs for which maintenance treatment is required to maintain community tenure *or*
 - 3) There is clinical evidence that additional treatment sessions are required to support termination of therapy, although the member no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued service authorization of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors and other relevant clinical indicators. Additionally, the treatment plan should include clear goals needing to be achieved and methods to achieve them in order to support successful termination (e.g., increasing time between appointments, use of community resources, and supporting personal success, etc.)
- D. The member does not require a higher level of care.

- E. The member appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Intensity and Quality of Service

For adults, Criteria A, B, C, D, E, F, G, H, I, J and K must be met to satisfy the criteria for intensity and quality of service. In addition, criterion L must be met for children/adolescents.

- A. There is documentation of a DSM-IV-TR diagnosis on Axis I, and there are completed assessments on Axes III, IV and V. The assessment also includes the precipitating event/presenting issues, specific symptoms and functional impairments, community and natural resources, personal strengths and the focus of treatment.
- B. There is a medically necessary and appropriate treatment plan, or its update, specific to the member's behavioral, psychological and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I. The treatment plan is expected to be effective in reducing the member's occupational, academic or social functional impairments and:
 - 1) Alleviating the member's distress and/or dysfunction in a timely manner *or*
 - 2) Achieving appropriate maintenance goals for a persistent illness *or*
 - 3) Supporting termination.
- C. The treatment plan must identify all of the following:
 - 1) Treatment modality, treatment frequency and estimated duration
 - 2) Specific interventions that address the member's presenting symptoms and issues
 - 3) Coordination of care with other health care services, (e.g., PCP or other behavioral health practitioners)
 - 4) The status of active involvement and/or ongoing contact with member's family and/or support system, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible
 - 5) The status of inclusion and coordination, whenever possible, with appropriate community resources
 - 6) Consideration/referral/utilization of psychopharmacological interventions for diagnoses that are known to be responsive to medication
 - 7) Documentation of objective progress toward goals for occupational, academic or social functional impairments, target-specific behavioral, psychological and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) being treated. Additionally, specific measurable interim treatment goals and specific measurable end of treatment goals, or specific measurable maintenance treatment goals

- (if this is maintenance treatment) are identified. Appropriate changes in the treatment plan are made to address any difficulties in making measurable progress
- 8) The description of an alternative plan to be implemented if the member does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are psychiatric evaluation if not yet obtained, a second opinion, or introduction of adjunctive or different therapies *and*
 - 9) The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria (I above). This evolving clinical status is documented by written contact progress notes.
- D. The member has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks and adhering to a medication regimen or other requirements of treatment.
 - E. Member is adhering to treatment recommendations, or non-adherence is addressed with the member, and barriers are identified, interventions are modified and/or treatment plan is revised as appropriate.
 - F. Although the member has not yet obtained the treatment goals, progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.
 - G. Treatment is effective as evidenced by improvement in GAF, SF-BH™, Consumer Health Inventory (CHI™) and/or other valid outcome measures.
 - H. Requested services do not duplicate other provided services.
 - I. Visits for this treatment modality are recommended to be no greater than one session per week, except for:
 - (i) acute crisis stabilization *or*
 - (ii) situations where the treating provider demonstrates more than one visit per week is medically necessary.
 - J. As the member exhibits sustained improvement or stabilization of a persistent illness, frequency of visits should be decreased over time (e.g., once every two weeks or once per month) to reinforce and encourage self-efficacy, autonomy, and reliance on community and natural supports
 - K. Consultations, office visits, individual psychotherapy and pharmacological management services when provided via telecommunication technology.

- L. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

Psychosocial Rehabilitation (PSR) Adult and Child/Adolescent

Criteria for Admission

The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission – Severity of Need

Criteria A (adults only), B, C and D must be met:

- A. Meets functional assessment criteria for target population under the 1915(i) for individuals 21 and older; or older than 18 years of age for 1915(i) only individuals.
- B. Adequate level of functioning without this service due to a mental health disorder as evidenced by (must meet 1 and either 2 or 3):
 - 1) Severe symptoms and/or history of severe symptoms for a significant duration *and*
 - 2) Inability to perform the activities of daily living *and/or*
 - 3) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.
- C. The member seeks and actively participates in a joint provider/member assessment and the provider/member jointly agree that the member desires, is committed to, will likely benefit from the rehabilitation process.
- D. The interventions necessary to reverse, stabilize or enhance the member's condition requires the frequency, intensity and duration of contact provided by the rehabilitative service as evidenced by:
 - 1) Failure to reverse/stabilize/progress with a less intensive intervention *and/or*
 - 2) Need for specialized intervention for a specific impairment or disability.

II. Admission – Intensity and Quality of Service

Criteria A through D must be met for adult. Criteria A through E must be met for child/adolescent.

- A. Services are to develop social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness,

develop coping strategies and effective functioning in the individual's social environment, including home, work and school.

- B. Services are to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.
- C. Services teach learned skills so the person can remain in a natural community location and achieve developmentally appropriate functioning.
- D. Services are to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- E. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met.

- A. An assessment appropriate to the recovery model indicates at least one of the following:
 - 1) As a result of the mental illness, there are or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues *or*
 - 2) There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the member *or*
 - 3) A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.
- B. The reasonable likelihood of substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.
- C. The member/family chooses to continue in the program.

Psychological Testing

Criteria for Authorization

Prior to psychological testing, the individual must be assessed by a qualified behavioral health care provider. The diagnostic interview determines the need for and extent of the psychological testing. Testing may be completed at the onset of treatment to assist in the differential diagnosis and/or help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed and there is no clear explanation for the lack of improvement.

I. Severity of Need

Criteria A, B and C must be met:

- A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.
- B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.
- C. The testing results based on the referral question(s) are reasonably expected to provide information that will effectively guide the course of treatment.

II. Intensity and Quality of Care

Criteria A and B must be met:

- A. A licensed doctoral-level psychologist or medical psychologist (Ph.D., Psy.D., Ed.D. or M.P.) or physician with demonstrated competence, who is credentialed by and contracted with Magellan, administers the tests.²
- B. Requested tests must be valid and reliable. The most recent version of the test must be used, except as outlined in the latest version of *Standards for Educational and Psychological Testing*.

III. Exclusion Criteria

Psychological testing will not be authorized under any of the following conditions:

- A. The testing is primarily for educational or vocational purposes.
- B. The testing is primarily for the purpose of determining if an individual is a candidate for a specific medication or dosage.
- C. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual is a candidate for a medical or surgical procedure.

² Psychometricians supervised by licensed psychologists/medical psychologists may administer psychological tests, but are not individually credentialed by Magellan.

Psychological Testing

- D. The testing results could be invalid due to the influence of a substance, substance abuse, substance withdrawal or any situation that would preclude valid psychological testing results from being obtained (e.g., an individual who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered).
- E. The testing is primarily for diagnosing attention-deficit hyperactive disorder (ADHD), unless the diagnostic interview, clinical observations and results of appropriate behavioral rating scales are inconclusive.
- F. Two or more tests are requested that measure the same functional domain.
- G. Testing is primarily for legal purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing.
- H. Requested tests are experimental, antiquated, or not validated.
- I. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.
- J. The testing is primarily to determine the extent or type of neurological impairment, unless allowed by the individual's benefit plan.
- K. The number of hours requested for the administration, scoring, interpretation and reporting exceeds the generally accepted standard for the specific testing instrument(s), unless justified by particular testing circumstances.