# Children's Mental Health Bureau
# Medicaid Services Provider Manual

May 12, 2023

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# Chapter 1 – Purpose and Definitions

## Purpose

The Children's Mental Health Bureau's (CMHB) Medicaid Services Provider Manual supplies provider information pertaining to the mental health services available to Montana Medicaid youth. Requirements pertain to all Medicaid provider types participating in the provision of these services.

This manual is adopted and incorporated into the Administrative Rules of Montana (ARM) 37.87.903.

Reimbursement for services are per their respective provider type reimbursement rules. *A determination of approval does not guarantee payment,* the Medicaid youth must also be determined eligible for the benefit. Payment is subject to the eligibility and applicable benefit provisions of the youth at the time the service was rendered. A provider should verify the Medicaid eligibility of the youth. Medicaid eligibility can be verified at: Montana Access to Health Web Portal.

For information about how to submit claims, please refer to: Provider Information Website; or Provider Relations at: 1.800.624.3958 or (406) 442.1837 (Helena only).

All services are subject to retrospective review for appropriateness by the Department or the Utilization Review Contractor.

## Definitions

For the manual, the following definitions apply:

(1) "Accredited Secondary School" means a secondary school located in the state of Montana accredited in accordance with Montana Board of Public Education standards for secondary education or the Northwest Accreditation Commission.

(2) "Authorized Representative" means as defined in ARM 37.5.304.

(3) "Functional impairment" means difficulties that substantially interfere with or limit functioning of the youth in multiple life domains and interfere with the achievement or maintenance of developmentally appropriate social, communicative, behavioral, cognitive, or adaptive skills. Functional impairment may be reflected in either internalizing or externalizing behaviors.

(4) "Medical Assistance Provider" means as defined in ARM 37.5.304.

(5) "System" means, as it pertains to Targeted Case Management, agencies, providers, state, tribal, or educational entities that must collaborate for the purpose of improving access and expanding the array of coordinated community-based services and supports for youth with a serious emotional disturbance and their families.

(6) "Utilization Review Contractor (UR Contractor)" means the entity under contract with the Children's Mental Health Bureau to complete agreed upon utilization review activities for Montana Medicaid Services.

(7) "Youth" means as defined in ARM 37.87.102.

# Chapter 2 – Coordination and Discharge

## Coordination of Services Provided Concurrently

Medicaid services must not be provided to a youth at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. **A table of services which may NOT be provided concurrently is on pages 8-12.**

(1) All providers must be mindful of all community-based services, regardless of funding source, that are potentially duplicative including those which are not in the Children's Mental Health Bureau's array of services. To avoid duplication, community-based services that are provided concurrently require coordination. Community-based services are those services which provide youth the opportunity to be served in their own home or community.

(2) The community-based services available through the Children's Mental Health Bureau are as follows:

(a) Therapeutic Group Home;
(b) Home Support Services;
(c) Therapeutic Foster Care;
(d) Therapeutic Foster Care-Permanency;
(e) Comprehensive School and Community Treatment;
(f) Day Treatment;
(g) Intensive Outpatient Therapy;
(h) Outpatient Therapy;
(i) Community Based Psychiatric Rehabilitation and Support Services; and
(j) Targeted Case Management

(3) Providers must demonstrate and document attempts made for coordination of community-based services by:

(a) Informing the parent or legal representative at intake of Medicaid's requirement for coordination of community-based services and documenting other services the youth and family are receiving (i.e., asking the parent or legal representative if they are receiving other mental health-related services and asking follow-up questions to determine which services they may be receiving);
(b) Obtaining a Release of Information (ROI) from the parent or legal representative of the youth for all providers identified by the parent or legal representative;
(c) Contacting the providers as indicated by the parent or legal representative to initiate coordination;
(d) Maintaining a copy of one single, coordinated treatment plan in each of the provider's youth files (preferred) or maintaining copies of all treatment plans in

effect to illustrate the lack of duplication; and
(e) Documenting each attempt to make reasonable efforts to coordinate treatment planning.

(4) The provider(s) must identify in the treatment plan(s) the role of each service or provider identified. The treatment plan must clearly state which provider is accountable for the identified goal(s) or objective(s).

(5) A provider must furnish a copy of the agency's treatment plan to the parent or legal representative.

(6) If the youth is receiving targeted case management associated with the mental illness or emotional disturbance of the youth, the case manager must be responsible for the coordination efforts in (1).

(7) The department is entitled to recover any payment a provider is not entitled to pursuant to ARM 37.85.406.

## Coordination of Outpatient Therapy Concurrent with Comprehensive School and Community Treatment (CSCT) and Therapeutic Group Home (TGH)

(1) The youth must meet SED criteria specific to the service being provided concurrently with Outpatient therapy and;
(a) The youth or their family must need a specific or specialized Outpatient therapy service in addition to their current services which the TGH or CSCT provider is not certified or trained to provide, or the type of therapy is not appropriate for the milieu. **Continuation of an existing therapeutic relationship with the previous outpatient therapist does not constitute a specific clinical need**;
(b) If the youth is transitioning in or out of the TGH from the community, Outpatient therapy services may be provided as needed within 60 days of the admission or discharge date, not to exceed a total of 24 sessions.

(2) To initiate Outpatient therapy when a youth is enrolled in CSCT or a TGH the provider must:
(a) Obtain a release of information from the legal representative of the youth for all other service providers;
(b) Contact the service provider(s) to verify enrollment; and
(c) Coordinate the services and treatment plan with all service providers.

| Service | May not be Provided Concurrently | Notes/Exceptions |
|---|---|---|
| Acute Hospital | All CMHB Services | TCM may be provided up to 60 consecutive days if provided for the purpose of community transition. |
| Partial Hospital Program (PHP) | Acute Hospital<br>PRTF<br>PRTF-AS<br>CSCT<br>Day<br>TX OP<br>CBPRS<br>ENA | CBPRS may not be provided during PHP program hours. |
| Psychiatric Residential Treatment Facility (PRTF) | Acute Hospital<br>PHP<br>PRTF-AS<br>TGH<br>HSS<br>TFC<br>TFOC-P<br>CSCT<br>Day<br>TX<br>IOP<br>OP<br>CBPRS<br>ENA | TCM may be provided up to 60 consecutive days if provided for the purpose of community transition.<br><br>Up to 96 units of HSS may be provided concurrently for discharge handoff. |
| Psychiatric Residential Treatment Facility Assessment Service (PRTF-AS) | Acute Hospital<br>PHP<br>PRTF<br>TGH<br>HSS<br>TFC<br>TFOC-P<br>CSCT<br>Day<br>TX<br>IOP<br>OP<br>CBPRS<br>ENA | None |

| Service | May not be Provided Concurrently | Notes/Exceptions |
|---|---|---|
| Therapeutic Group Home (TGH) | Acute Hospital<br>PRTF<br>PRTF-AS<br>HSS<br>TFC<br>TFOC-P<br>IOP<br>OP<br>CBPRS (Individual) | See coordination of OP with TGH and CSCT section for exceptions and coordination requirements.<br><br>Individual CBPRS may not be provided during TGH program hours. Group CBPRS may be provided concurrently with TGH.<br><br>Up to 96 units of HSS may be provided concurrently for discharge handoff. |
| Home Support Services (HSS) | Acute Hospital<br>PRTF<br>PRTF-AS<br>TGH<br>TFC<br>TFOC-P<br>IOP<br>ENA | PRTF and TGH may be provided concurrently up to 96 units for discharge handoff. |
| Therapeutic Foster Care (TFC) | Acute Hospital<br>PRTF<br>PRTF-AS<br>TGH<br>HSS<br>TFOC-P<br>IOP<br>ENA | None |
| Therapeutic Foster Care – Permanency (TFOC-P) | Acute Hospital<br>PRTF<br>PRTF-AS<br>TGH<br>HSS<br>TFC<br>IOP<br>ENA | None |

| Service | May not be Provided Concurrently | Notes/Exceptions |
|---|---|---|
| Comprehensive School and Community Treatment (CSCT) | Acute Hospital<br>PHP<br>PRTF<br>PRTF-AS<br>DAY TX<br>IOP<br>CBPRS<br>OP<br>ENA | CBPRS may not be provided during the regular school hours of the youth when the youth is enrolled in CSCT.<br><br>See Coordination of OP with TGH and CSCT section for exceptions and coordination requirements. |
| Day Treatment (Day TX) | Acute Hospital<br>PHP<br>PRTF<br>PRTF-AS<br>CSCT<br>IOP<br>CBPRS<br>ENA | CBPRS may not be provided during Day TX program hours.<br><br>ENA may not be provided during Day TX program hours. |
| Intensive Outpatient Therapy | Acute Hospital<br>PRTF<br>PRTF-AS<br>TGH<br>CSCT<br>Day TX<br>HSS<br>TFC<br>TFOC-P<br>OP<br>ENA | |
| Outpatient Therapy (OP) | Acute Hospital<br>PHP<br>PRTF<br>PRTF-AS<br>TGH<br>CSCT<br>IOP<br>ENA | See Coordination of OP with TGH and CSCT section for exceptions and coordination requirements. |
| Targeted Case Management (TCM) | None | TCM may be provided up to 60 consecutive days if provided for the purpose of community transition. |

| Service | May not be Provided Concurrently | Notes/Exceptions |
|---|---|---|
| Therapeutic Home Visit (THV) | Acute Hospital<br>PHP<br>PRTF-AS<br>HSS<br>TFC<br>TFOC-P<br>CSCT<br>Day TX<br>IOP<br>OP<br>CBPRS<br>ENA | None |
| Community Based Psychiatric Rehabilitation and Support Services (CBPRS) | Acute Hospital<br>PHP<br>PRTF<br>PRTF-AS<br>TGH<br>CSCT<br>Day TX<br>ENA | CBPRS may not be provided during PHP program hours.<br><br>Individual CBPRS may not be provided during TGH program hours. Group CBPRS may be provided concurrently with TGH.<br><br>CBPRS may not be provided during regular school hours of the youth when the youth is enrolled in CSCT.<br><br>CBPRS may not be provided during Day TX program hours. |
| Extraordinary Needs Aide (ENA) | Acute Hospital<br>PHP<br>PRTF<br>PRTF-AS<br>HSS<br>TFC<br>TFOC-P<br>CSCT<br>Day TX<br>IOP | ENA may only be provided to a youth who is currently receiving Therapeutic Group Home services. |

| Service | May not be Provided Concurrently | Notes/Exceptions |
|---|---|---|
| | OP<br>CBPRS | |

## Discharge from Services

**Failure to properly discharge a youth may prevent the youth from receiving proper services because a new prior authorization approval and prior authorization number cannot be issued until the Department or the Utilization Review Contractor receives a *Discharge Notification* from the previous provider.**

Upon the discharge of the youth from services which require the provider to notify the Utilization Review Contractor, the provider must complete the discharge task in the Utilization Management portal. The timeframes for the provider to complete the discharge task vary by service and are listed in the services specific section below.

| Service | Submit to | Within |
|---|---|---|
| Psychiatric Residential Treatment Facility (PRTF) | Utilization Review Contractor | 1 business day |
| Therapeutic Group Home | Utilization Review Contractor | 5 business days |

## Discharge Criteria

(1) A discharge plan must be formulated upon admission of a youth into a service and:

(a) Be reviewed and updated during the treatment team meetings;
(b) Identify specific target dates for achieving the goals and objectives of the youth;
(c) Define criteria for conclusion of treatment at the current level of care; and
(d) Identify step down alternatives, if applicable.

(2) A youth must be discharged when the treatment plan goals have been sufficiently met such that the youth no longer meets the clinical guidelines of the level of care for the service.

(3) A parent or legal representative of the youth may remove the youth from the service.

(4) Youth who are not court ordered to participate in the service may voluntarily leave the service pursuant to 53-21-112 MCA.

## Discharge After a Denial

Both the provider and parents/legal representatives must make plans for discharge when a denial is issued, whether or not additional days for discharge planning are authorized. Additional days for discharge planning will only be reimbursed with prior approval from the department or the Utilization Review Contractor and failure to discharge may result in non-payment to providers. Providers and parents/legal representatives should not delay planning for discharge pending the outcome of an administrative review/fair hearing if one is requested.

## Youth Leaving a Correctional Facility

The Department of Corrections (DOC) staff will need to work with the service staff to complete a Medicaid application. Medicaid eligibility is determined by the Office of Public Assistance (OPA). The DOC may request a retrospective review of the prior authorization back to the date the Medicaid eligibility was determined.

If at any time during the placement, the youth no longer meets clinical guidelines OR is ineligible for Medicaid, the DOC becomes financially responsible for the cost of the placement for youth committed to the DOC.

***For a youth in a correctional facility that needs access to treatment:***

(1) Youth in a correctional facility are not Medicaid eligible and cannot be determined for eligibility prior to admission into a service. If parents retain guardianship for a youth committed to the DOC, parent income is used to determine Medicaid eligibility when the youth leaves the correctional facility.

(2) A youth who is court ordered into services must still meet the requirements for prior authorization and medical necessity criteria for the purpose of Montana Medicaid reimbursement.

(3) If a youth is determined to be Medicaid eligible after admission, the youth must also meet clinical management guidelines for Montana Medicaid reimbursement.

(4) Once the youth is Medicaid eligible, the provider must complete a request for Prior Authorization and a Certificate of Need (CON), if applicable, and submit these for utilization review within 14 days.

# Chapter 3 – Clinical Guidelines and Services

The following clinical guidelines must be employed for each covered Medicaid mental health service. Current forms required for utilization management are available on the CMHB website at CMHB Provider Forms and on the website of the Utilization Management Contractor. The forms for each service include the information regarding where and how to submit the form for the specific service.

## Serious Emotional Disturbance (SED)

(1) To qualify with a serious emotional disturbance (SED), youth aged six and older must:

(a) Have been determined by a licensed mental health professional as having a mental disorder on the list below. When the SED diagnosis includes specifiers and/or severity levels, it is expected that these will be included with the diagnosis; and

(b) Meet the functional impairment criteria requirements listed in this section.

(2) To qualify with a SED, youth under the age of six must:

(a) Have a diagnosis or condition that may be a focus of clinical attention as listed in the current Diagnostic and Statistical Manual of Mental Disorders (DSM). A primary diagnosis from the table below is not required for youth under the age of 6; and

(b) Meet the functional impairment criteria requirements listed in this section.

(3) A youth must be re-assessed annually (within 12 calendar months of the last determination) by a licensed mental health professional to determine the youth still meets the criteria in (1) or (2) above. The clinical assessment must document how the youth meets the criteria for having a SED, including specific functional impairment criteria.

(4) Youth who continue to meet the SED criteria who are receiving children's mental health services, with the exception of PRTF services, may continue to receive services up to age 20 if they demonstrate:

(a) A continued need for the services; and

(b) Attendance at an accredited secondary school.

## Serious Emotional Disturbance (SED) Diagnoses from the Current DSM

**Neurodevelopmental Disorders**

- Autism Spectrum Disorder
- Attention Deficit/Hyperactivity Disorder (if accompanied by another SED diagnosis)
- Other Specified Neurodevelopmental Disorder

**Schizophrenia Spectrum and Other Psychotic Disorders**

- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder, Bipolar Type
- Schizoaffective Disorder, Depressive Type
- Other Specified Schizophrenia Spectrum and other Psychotic Disorder

**Bipolar and Related Disorders**

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Other Specified Bipolar and Related Disorder

**Depressive Disorders**

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder, single episode
- Major Depressive Disorder, recurrent episode
- Persistent Depressive Disorder (Dysthymia)
- Other Specified Depressive Disorder

**Anxiety Disorders**

- Separation Anxiety Disorder
- Panic Disorder
- Generalized Anxiety Disorder
- Other Specified Anxiety Disorder

**Obsessive-Compulsive and Related Disorders**

- Obsessive-Compulsive Disorder
- Other Specified Obsessive-Compulsive and Related Disorder

**Trauma- and Stressor-Related Disorders**

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Other Specified Trauma- and Stressor-Related Disorder

**Dissociative Disorders**

- Dissociative Identity Disorder
- Other Specified Dissociative Disorder

**Somatic Symptom and Related Disorders**

- Somatic Symptom Disorder
- Conversion Disorder
- Other Specified Somatic Symptom and Related Disorder

**Feeding and Eating Disorders**

- Anorexia Nervosa
- Bulimia Nervosa
- Other Specified Feeding or Eating Disorder

**Gender Dysphoria**

- Gender Dysphoria
- Other Specified Gender Dysphoria

**Disruptive, Impulse-Control, and Conduct Disorders**

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Other Specified Disruptive and Impulse Control Disorder

## Serious Emotional Disturbance (SED) Functional Impairment

(1) Youth aged six and older, as a result of their primary qualifying SED diagnosis, must consistently demonstrate active symptomatology that cannot be attributed to intellectual, sensory, or health factors, and has resulted in substantial impairment in functioning for at least six months or is reasonably predicted to last at least six months, as manifested by **two or more** of the following**:**

(a) Failure to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;

(b) Failure to establish or maintain developmentally and culturally appropriate peer relationships;

(c) Failure to demonstrate a developmentally appropriate range and expression of emotion or mood;

(d) Disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreational settings;

(e) Behavior that is seriously detrimental to the youth's growth, development, safety, or welfare, or to the safety or welfare of others; or

(f) Behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

(2) Youth under age six must consistently demonstrate active symptomatology that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least six months and is reasonably predicted to last at least six months, as manifested by **one or more** of the following:

(a) Atypical, disruptive, or dangerous behavior which is aggressive or self-injurious;

(b) Atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;

(c) Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent, or hypersexual;

(d) Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;

(e) Indiscriminate sociability (e.g., excessive familiarity with strangers) that increases risk to the personal safety of the youth; or

(f) Inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers.

# Services

## Acute Inpatient Hospital Services

Administrative Rules of Montana Title 37, Chapter 86, Subchapter 29

**Definition** Acute Inpatient Hospital is a psychiatric facility accredited by the Joint Commission on Accreditation of Health Care Organizations that is devoted to the provision of inpatient psychiatric care for persons under the age of 21 and licensed as a hospital by:

(a) The Department; or

(b) An equivalent agency in the state in which the facility is located.

**Medical Necessity Criteria – Acute Inpatient Hospital**

**Admission to acute inpatient hospital services requires the youth to have a current DSM diagnosis that is covered under the provisions of the Montana Medicaid Program as the primary diagnosis and youth must exhibit at least one of the following:**

(1) Danger to self or others with continued acuity of risk that cannot be appropriately treated in a less restrictive level of care.

(2) Severe functional impairment related to the symptoms of the mental illness or emotional disturbance of the youth, sufficient to render the youth or caregiver of the youth unable to reasonably provide for the safety and well-being of the youth.

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| Certificate of Need (CON) | A CON is not required.<br>The requirements at 42 CFR 456.60 are met by having the physician admit the youth. |
| Prior Authorization | Not required for in-state acute inpatient hospital. **Prior authorization is required for out-of-state facilities** and must be submitted to the UR Contractor within one business day of admission to the facility. Computing time for authorization requests includes weekends and holidays. If a deadline falls on a weekend or holiday the deadline is the next business day. |
| Service Requirements | Acute inpatient hospital services must be provided in accordance with all state and federal regulations pertaining to the administration of the service. |
| Continued Stay Criteria | Not Required. Acute inpatient services are reimbursed based on All Patient Refined Diagnostic Related Groups (APR-DRGs). |
| Continued Stay Review | Not Required. Acute inpatient services are reimbursed based on All Patient Refined Diagnostic Related Groups (APR-DRGs). |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |

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| Additional Information | Not applicable. |

## Psychiatric Residential Treatment Facility (PRTF)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 12

**Definition** Psychiatric Residential Treatment Facility means a facility accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or any other organizations designated by the Secretary of the United States Department of Health and Human Services as authorized to accredit psychiatric hospitals for Medicaid participation, and which operates for the primary purpose of providing residential psychiatric care to persons under 21 years of age. (The youth must meet the Montana Medicaid SED criteria for PRTF services.)

**Medical Necessity Criteria – PRTF**

**Youth must meet the SED criteria as described in this manual and:**

(1) The referring provider must document what specific treatment needs will be addressed with PRTF services.

(2) The youth must require:

(a) Intensive psychiatric review and intervention, which may include adjustment of psychotropic medications, evidenced by either rapid deterioration or failure to improve despite clinically appropriate treatment in a less restrictive level of care; and

(b) Medical supervision seven days per week/24 hours per day to develop skills necessary for daily living and to develop the adaptive and functional behavior that will allow the youth to live outside of the PRTF.

(3) Less restrictive services are insufficient to meet the severe and persistent clinical and treatment needs of the youth and prohibits treatment in a lower level of care which is evidenced by at least one of the following:

(a) The youth has behavior that puts the youth at substantial documented risk of harm to self;

(b) The youth has persistent, pervasive, and frequently occurring oppositional defiant behavior, aggression, or impulsive behavior related to the SED diagnosis which represents a disregard for the wellbeing or safety of self or others; or

(c) There is a need for continued treatment beyond the reasonable duration of an acute care hospital and documented evidence that appropriate intensity of treatment cannot be provided in a community setting.

(4) The prognosis for treatment at PRTF level of care can reasonably be expected to improve the clinical condition/SED of the youth or prevent further regression

based upon the physician's evaluation.

(5) In the absence of PRTF treatment, the youth is at risk of acute psychiatric hospitalization or a readmission within 30 days of previous admission to an acute psychiatric hospital.

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|---|---|
| Certificate of Need (CON) | **A CON is required.**<br>The provider must submit a CON in accordance with 42 CFR 441.152 and 441.153 to the Utilization Review Contractor no later than two business days prior to admission to the facility. The CON must be completed within 30 days before the admission of the youth to the requested level of care and signed before the youth receives treatment. The provider must maintain the original signed CON and send a copy to the department or the Utilization Review Contractor. |
| Prior Authorization | **Prior authorization is required.**<br>(1) The provider must submit to the Utilization Review Contractor a prior authorization request no later than two business days prior to admission which includes an adequate demographic and clinical assessment. The clinical assessment must be sufficient for the clinical reviewer to make a determination regarding medical necessity. Computing time for prior authorization requests includes weekends and holidays. If a deadline falls on a weekend or holiday the deadline is the next business day.<br>(2) If the youth becomes Medicaid eligible while at the facility, the provider must submit a prior authorization request and a CON to the Utilization Review Contractor immediately upon learning the youth is Medicaid eligible.<br>(3) Upon receipt of the above documentation, the Utilization Review Contractor will complete the following review process:<br>(a) A clinical reviewer will complete the authorization review within two business days from receipt of the original review request and clinical information if the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.<br>(b) If the clinical reviewer determines that additional information is needed to complete the review, the review is pended and the provider must submit the requested information within five business days of the request for additional information. If the requested information is not received within this time frame, the clinical reviewer will issue a technical denial.<br>(c) The clinical reviewer will complete the authorization review within two business days from receipt of additional information.<br>(d) The clinical reviewer will authorize the admission and generate notification to all relevant parties if medical necessity criteria are met and the CON has been completed at least two business days prior to admission.<br>(e) The clinical reviewer will defer the case to a board-certified psychiatrist for review and determination if medical necessity criteria are not met. |

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| | **For a youth to be admitted into an out of state PRTF:**<br>(1) The provider must request admission from of all Montana PRTFs and be denied admission. The provider must document the denials in the file of the youth and complete the Out-of-State Screening Assessment in the Utilization Management portal.<br>(2) The Montana PRTFs may deny services for one of the following reasons:<br>(a) The facility cannot meet the clinical and/or treatment needs of the youth; or<br>(b) An opening is not available.<br>(3) The Montana PRTFs must specify the reasons the facility is unable to meet the needs of the youth or state when the next bed opening will be available for the youth.<br>(4) Legal representatives of all Montana Medicaid youth who are admitted to OOS PRTFs must complete an Interstate Compact Agreement before the youth leaves the state as part of the prior authorization process. The form is located on the department's website at: CMHB Provider Forms. |
| Service Requirements | The Psychiatric Residential Treatment Facility must provide services in accordance with all applicable state and federal regulations and meet the following requirements:<br>(1) A physician must:<br>(a) Complete an evaluation of the youth within 24 hours of admission; and<br>(b) Provide weekly treatment to the youth in order to make treatment adjustments to stabilize the psychiatric disorder of the youth.<br>(2) All legal representatives of the youth, including the Montana Care Coordinator assigned to the youth, must be consulted and invited to participate in the development and review of the treatment plan. The reasons must be documented if it is not clinically appropriate or feasible to consult and invite the legal representatives.<br>(3) A comprehensive discharge plan directly linked to the behaviors and/or symptoms that resulted in admission and including an estimated length of stay must be developed upon admission.<br>(4) As part of the discharge planning requirements, PRTFs must ensure the youth has a minimum of a seven-day supply of needed medication and a written prescription for medication to last through the first outpatient visit in the community with a prescribing provider. Prior to discharge, the PRTF must identify a prescribing provider in the community and schedule an outpatient visit. Documentation of the medication plan and arrangements for the outpatient visit must be included in the medical record for the youth. If medication has been used during the PRTF treatment of the youth, but is not needed upon discharge, the reason the medication is being discontinued must be documented in the medical record for the youth.<br>(5) If the youth is a student with disabilities, an Individual Education Plan (IEP) must be in place that provides programs and services consistent with requirements under IDEA and state special education requirements. If the youth is not a student with disabilities, educational services and programs must be designed to meet the educational needs of the youth.<br>(6) PRTF services must meet the educational goals of the youth. The PRTF must: |

| | |
|---|---|
| | (a) Follow as closely as possible an already existing IEP until the IEP is revised or a new IEP is developed; or<br>(b) Develop an education plan for a youth without an IEP appropriate to the needs of the youth.<br>(7) A written notification that includes any credits that the youth earned while in the PRTF must be provided to the school which the youth will be attending upon discharge prior to the discharge of the youth. For youth not returning to school, send transcripts and credits earned to the home school of record for the youth. |
| Continued Stay Criteria | (1) The youth continues to meet all Medical Necessity Criteria and all of the following:<br>(a) The medical record documents progress toward identified treatment goals and the reasonable likelihood of continued progress as;<br>(b) The youth and family, if appropriate, are demonstrating documented progress toward identified treatment goals and are cooperating with the treatment plan; and<br>(c) Demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The treatment team must document a clinical rationale for any recommended changes in the discharge plan or anticipated discharge.<br>(2) The UR contractor may approve up to 30 additional days to complete discharge planning per stay. The provider must document all previous attempts to secure appropriate discharge for the youth. |
| Continued Stay Review | The provider facility must submit a continued stay request to the Utilization Review Contractor no more than 10 business days before and no less than five business days prior to the termination of the current certification.<br>(1) The following information must be submitted for a continued stay review:<br>(a) Changes to current DSM diagnosis;<br>(b) Justification for continued services at this level of care;<br>(c) Description of behavioral management interventions and critical incidents;<br>(d) Assessment of treatment progress related to admitting symptoms and identified treatment goals;<br>(e) List of current medications and rationale for medication changes, if applicable; and<br>(f) Projected discharge date and clinically appropriate discharge plan, citing evidence toward completion of that plan.<br>(2) Upon receipt of the above information, the clinical reviewer will complete the continued stay review process:<br>(a) The continued stay review will be completed within two business days from receipt of the original review request provided the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.<br>(b) If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five business days of the request for additional information.<br>(c) The continued stay review will be completed within two business days from receipt of additional information. |

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| | (d) The clinical reviewer will authorize the continued stay and generate notification to all appropriate parties if the continued stay meets the medical necessity criteria.<br>(e) The clinical reviewer will defer the case to a board-certified psychiatrist for review and determination if the continued stay does not mee the medical necessity criteria.<br><br>For PRTF services, the continued stay request, when completed in its entirety by a physician, physician's assistant, or a nurse practitioner, may serve as the CON recertification as required under 42 CFR 456.60 (b). |
| Benefit Exclusion Criteria | (1) The primary problem is social, economic, or one of physical health without concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration or legal system intervention.<br>(2) A youth may not be placed in a PRTF due to lack of room and board funding in lower levels of care. |
| Required Forms | **In-State**<br>Certificate of Need (PRTF/PRTF-AS)<br><br>**Out-of-State**<br>Certificate of Need (PRTF/PRTF-AS)<br>Interstate Compact Agreement |
| Additional Information | **For youth with SED and Developmental Disability:**<br>(1) If not previously submitted, the PRTF must submit a request for an eligibility determination to the Department's Developmental Disability Program (DDP) for you aged 8 to 18 years suspected of having a developmental disability. An eligibility determination for adult services may be requested for youth 16 years or older.<br>(a) The PRTF must completed and submit to the DDP a cover letter along with the psychological testing and assessments required by the DDP; and<br>(b) The PRTF must completed and submit additional documentation if requested by the DDP.<br><br>**Corrections to Information**<br>To correct any information provided to the Utilization Review Contractor, the provider must contact the Utilization Review Contractor Directly.<br><br>**Discharge Notification**<br>The discharge task must be completed in the Utilization Management portal within one business day of discharge. |

## Psychiatric Residential Treatment Facility Assessment Service (PRTF-AS)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 12

**Definition** PRTF Assessment Services are short-term, intensive lengths of stay of 14 days or less provided by in state PRTFs, targeted to serve youth with multiple diagnoses and risk factors who present as "difficult to place." PRTF-AS may be used to:

(a) Continue the stabilization of a youth discharging from the acute setting to permit a safe return to the home environment and/or community-based services.
(b) Avert an admission to acute hospital care when symptoms that have led to hospital admissions in the past begin to emerge but are not yet acute.
(c) Assess whether the youth has specialized treatment needs in PRTF level of care.

**Medical Necessity Criteria – PRTF-AS**

**Youth must meet the SED criteria as described in this manual and:**

(1) Behaviors or symptoms of serious emotional disturbance of the youth are of a severe and persistent nature and require 24-hour treatment under the direction of a physician.

(2) Less restrictive services are insufficient to meet the severe and persistent clinical and treatment needs of the youth. The prognosis for treatment at this PRTF level of care can reasonably be expected to improve the clinical condition/serious emotional disturbance of the youth or prevent further regression based upon the physician's evaluation.

(3) The youth:
(a) Has had multiple acute psychiatric hospital or PRTF admissions;
(b) Is at-risk of being placed in an out-of-state PRTF with an unclear psychiatric presentation; or
(c) Is difficult to place due to an unclear or conflicting psychiatric presentation.

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| Certificate of Need (CON) | **A CON is required.**<br>The provider must submit a CON in accordance with 42 CFR 441.152 and 441.153 to the Utilization Review Contractor no later than two business days prior to admission to the facility. The CON must be completed no more than 30 days before the admission of the youth to the requested level of care and signed before the youth receives treatment. The provider must maintain the original signed CON and send a copy to the Utilization Review Contractor. |

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| Prior Authorization | **Prior authorization is required.**<br>(1) The provider must submit a prior authorization request to the Utilization Review Contractor no later than two business days prior to admission. Computing time for prior authorization requests includes weekends and holidays. If a deadline falls on a weekend or holiday the deadline is the next business day.<br>(2) The provider must submit a prior authorization request to the Utilization Review Contractor for a youth who is being transferred from inpatient psychiatric hospital services to PRTF-AS services no later than two business days prior to the transfer.<br>(3) A completed CON must accompany the prior authorization request.<br>(4) If the youth becomes Medicaid eligible while at the facility, the provider must submit a prior authorization request and a CON to the Utilization Review Contractor immediately upon learning the youth is Medicaid eligible.<br>(5) The provider must request prior authorization from the Utilization Review Contractor for full PRTF services no later than two business days before the end of the PRTF-AS authorization if additional days beyond fourteen are needed. |
| Service Requirements | Psychiatric Residential Treatment Facility-Assessment Services must be provided in accordance with all applicable state and federal regulations and meet the following requirements:<br>(1) The youth must be evaluated by a physician within 24 hours of admission;<br>(2) All legal representatives of the youth must be consulted and invited to participate in the development and review of the treatment plan. Valid reasons must be indicated if such a plan is not clinically appropriate or feasible.<br>(3) A comprehensive discharge plan directly linked to the behaviors and/or symptoms that resulted in admission and estimated length of stay must be developed upon admission.<br>(4) If the youth is a student with disabilities, an Individualized Education Plan (IEP) must be in place that provides programs and services consistent with requirements under IDEA and state special education requirements. If the youth is not a student with disabilities, educational services and programs must be designed to meet the educational needs of the youth.<br>(5) PRTF-AS services must meet the educational goals of the youth. The PRTF must:<br>(a) Follow as closely as possible an already existing IEP until the IEP is revised or a new IEP is developed; or<br>(b) Develop an educational plan for a youth without an IEP appropriate to the needs of the youth.<br>(6) A written notification that includes any credits the youth earned while in the PRTF must be provided to the school in which the youth will be attending upon discharge, prior to the discharge of the youth. |
| Continued Stay Criteria | Continued Stay criteria are not applicable due to the 14-day limitation of this service. |

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| Continued Stay Review | A Continued Stay review is not applicable due to the 14-day limitation of this service. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Certificate of Need (PRTF/PRTF-AS) |
| Additional Information | **Discharge Notification**<br>The discharge task must be completed in the Utilization Management portal within one business day of discharge. |

## Partial Hospital Services (PHP)

Administrative Rules of Montana Title 37, Chapter 86, Subchapter 30

**Definition** Partial Hospital Services (PHP) is defined as an active treatment program that offers therapeutically intensive, coordinated, structured clinical services provided only to youth who are determined to have a serious emotional disturbance. Partial hospitalization services are time-limited and provided within either an acute level program or a sub-acute level program. Partial hospitalization services employ an integrated, comprehensive, and complementary schedule of recognized treatment or therapeutic activities.

Acute level partial hospitalization as described in ARM 37.86 subchapter 30 is provided by programs which:

(a) Are operated by a hospital as defined in 50-5-101 MCA, and are collocated with that hospital such that in an emergency a patient of the acute partial hospitalization program can be transported to the hospital's inpatient psychiatric unit within 15 minutes;
(b) Serve primarily persons being discharged from inpatient psychiatric treatment or inpatient psychiatric residential treatment; and
(c) Provide psychotherapy services consisting of at least individual, family, and group sessions at a frequency designed to stabilize the person sufficiently to allow discharge to a less intensive level of care at the earliest appropriate opportunity.

Sub-acute level partial (SAP) hospitalization is provided by programs which:

(a) Operate under the license of a general hospital in a self-contained facility, distinct psychiatric unit, or an inpatient psychiatric hospital for persons under 21;
(b) Offer integrated mental health services appropriate to the needs of the youth as identified in an individualized treatment plan; and
(c) Serve youth with a serious emotional disturbance being discharged from inpatient psychiatric treatment, residential treatment, or who would be admitted to such treatment in the absence of partial hospitalization.

**Medical Necessity Criteria – PHP**

**Youth must meet the SED criteria as described in this manual and:**

(1) The clinical condition of the youth requires a structured day program with active psychiatric treatment under the direction of a physician with frequent nursing and medical supervision.

(2) The youth has exhausted or cannot be safely treated in a less intensive level of care and the partial hospital program can safely substitute for or lessen the time for a discharge from an acute hospital.

(3) The treatment plan is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the youth to receive services in a less intensive outpatient setting.

(4) The youth can be safely and effectively managed in a partial hospital setting without significant risk of harm to self/others.

(5) The services can reasonably be expected to improve the clinical condition of the youth or prevent further regression.

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | Prior authorization is not required. |
| Service Requirements | Partial Hospitalization Services must be provided in accordance with all applicable state and federal regulations and meet the following requirements:<br>(1) The provider must:<br>(a) Complete a clinical assessment within 10 business days of admission;<br>(b) Provide a face-to-face evaluation completed by a physician;<br>(c) Involve all legal representatives in evaluation, treatment planning activities, and in treatment, or provide documentation which indicates valid reasons why such participation is not clinically appropriate or feasible;<br>(d) Initiate active discharge planning at the time of admission to the program and culminate into a comprehensive discharge plan;<br>(e) Develop and implement a comprehensive treatment plan that is updated every 30 days or earlier as needed, to reflect progress of the youth;<br>(f) Provide education services through full collaboration with a school district, certified education staff within the program, or an interagency agreement with an accredited school;<br>(g) Provide crisis intervention and management, including response outside of the program setting; and<br>(h) Provide psychiatric evaluation, consultation, and medication management as appropriate to the needs of the youth. |
| Continued Stay Criteria | The youth continues to meet ALL admission criteria and all of the following:<br>(1) Lower levels of care are inadequate to meet the needs of the youth;<br>(2) Active treatment is occurring, which is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the youth to receive services in a less intensive outpatient setting;<br>(3) Demonstrated and documented progress is being made toward the treatment goals and there is a reasonable likelihood of continued progress |

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| | including a reduced probability of future need for a higher level of care; and (4) Demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The treatment team must provide a clinical rationale for any recommended changes in the discharge plan or anticipated discharge date. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Therapeutic Group Home (TGH)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 10

**Definition** Therapeutic Group Homes provide behavioral intervention and life skills development in a structured group home environment for youth who cannot be served in an outpatient setting due to safety concerns or functional impairments that result from serious emotional disturbance. The purpose of the therapeutic and behavioral interventions is to improve the youth's functioning in one or more areas so that they can be successful in a home setting and to encourage personal growth and development. Therapeutic Group Home Services include:

(a) Individual, Group and Family Therapy
(b) Behavioral and life skills training

**Medical Necessity Criteria – TGH**

**Youth must meet the SED criteria as described in this manual and:**

(1) The prognosis for treatment of the serious emotional disturbance of the youth at a less restrictive level of care is poor because the youth demonstrates three or more of the following due to the serious emotional disturbance:

(a) Significantly impaired interpersonal or social functioning;
(b) Significantly impaired educational or occupational functioning;
(c) Impairment of judgment;
(d) Poor impulse control; or
(e) Lack of family or other community or social networks.

(2) As a result of the serious emotional disturbance, the youth exhibits an inability to perform daily living activities in a developmentally appropriate manner.

(3) As a result of the emotional disturbance or mental illness, the youth exhibits internalizing or externalizing behavior that results in an inability for a caregiver to safely provide care and structure for the youth in a family setting.

(4) The SED symptoms of the youth are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient or in-home mental health service.

(5) The youth exhibits behaviors related to the SED diagnosis that result in significant risk for placement in a PRTF or acute care if TGH services are not provided, or the youth is currently being treated or maintained in a more

restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting.

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| Certificate of Need (CON) | A CON is not required |
| Prior Authorization | **Prior authorization is required.**<br>(1) The Utilization Review Contractor may issue the prior authorization for as many days as deemed medically necessary up to 120 days. Authorization for less than 120 days does not constitute a (partial) denial of services. A provider may request a continued stay prior to the end of the initial stay authorization timeframe.<br>(2) The Utilization Review Contractor must receive the request for prior authorization no earlier than 10 business days prior to the admission of the youth. Requests received earlier than 10 days prior the admission of the youth will be technically denied. If a request is received after the youth has been admitted, the request will be considered from the date the request was received by the Utilization Review Contractor. Computing time for prior authorization requests includes weekends and holidays. If a deadline falls on a weekend or holiday the deadline is the next business day.<br>(3) If the youth becomes Medicaid eligible while at the therapeutic group home, the provider must submit a prior authorization request to the Utilization Review Contractor immediately upon learning the youth is Medicaid eligible.<br>(4) The clinical reviewer will complete the review process within two business days of receipt of complete information and take one of the following actions:<br>(a) Request additional information as needed to complete the review, the provider must submit the requested information within five business days of the request for additional information.<br>(b) Authorize up to 120 days as medically necessary and generate notification to all appropriate parties if the request meets the medical necessity criteria.<br>(c) Defer the case to a board-certified psychiatrist for review and determination if medical necessity criteria are not met.<br>(5) The board-certified psychiatrist will complete the review and determination within four business days of receipt of the information from the clinical reviewer.<br>(6) After a denial, a new prior authorization request may be submitted only if there is new clinical information.<br>(7) For youth being readmitted into TGH services within 14 calendar days of a discharge from TGH services, see continued stay criteria.<br><br>**For youth in emergency situations who meet the medical necessity criteria for TGH level of care:**<br>A TGH provider may request payment authorization of services for up to 72 hours pending a prior authorization determination:<br>(a) The provider must state the nature of the emergency; and<br>(b) For youth discharging from an acute setting, the physician must certify that the youth is safe to discharge to a TGH. |
| Service Requirements | Therapeutic Group Home Services must be provided in accordance with all applicable state and federal regulations and meet the following requirements:<br>(1) A provider must:<br>(a) Document in the file of the youth how the youth meets the medical necessity criteria within one business day of admission;<br>(b) Complete and maintain a clinical assessment in accordance with ARM 37.97.905. The prior authorization request does not serve to meet the |

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| | requirement of the clinical assessment. The clinical assessment must meet the requirements as described in ARM 37.97.102(4);<br>(c) Meet the therapeutic service requirements as described in ARM 37.97.906;<br>(d) Meet the treatment plan requirements as described in ARM 37.97.907;<br>(e) Document attempts to engage the legal representative in treatment planning and progress toward an appropriate discharge placement; and<br>(f) Complete the discharge task in the Utilization management portal within ten business days of the discharge of a youth from the TGH. |
| Continued Stay Criteria | Continued stay requests will be considered only when the youth continues to meet the SED criteria and all of the following:<br>(1) The prognosis for treatment of the serious emotional disturbance at a less restrictive level of care remains poor because the youth still demonstrates two or more of the following:<br>(a) Significantly impaired interpersonal or social functioning;<br>(b) Significantly impaired educational or occupational functioning;<br>(c) Impairment of judgment; or<br>(d) Poor impulse control.<br>(2) As a result of the serious emotional disturbance, the youth exhibits an inability to perform daily living activities in a developmentally appropriate way without the structure of the TGH.<br>(3) The SED symptoms of the youth are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient or in-home mental health service.<br>(4) The youth has demonstrated progress toward identified treatment goals and has a reasonable likelihood of continued progress.<br>(5) If a provider discharges a youth from TGH services and the youth is readmitted into TGH services in less than 14 calendar days, a provider must submit a continued stay request no earlier than 10 business days and no later than two business days prior to the readmission of the youth. |
| Continued Stay Review | (1) The Utilization Review Contractor may issue the continued stay for as many days as deemed medically necessary up to 90 days. A provider may request a continued stay prior to the end of the initial stay authorization timeframe.<br>(2) The Utilization Review Contractor must receive the request for continued stay no earlier than 30 business days prior to the end of the current authorized time period. Requests received earlier than 30 days prior to the end of the current authorization will be technically denied. If a request is received after the authorized time period has expired, the request will be considered from the date received by the Utilization Review Contractor. The Utilization Review Contractor will not retroactively authorize days if a continued stay request is received late.<br>(3) The following information must be submitted to the Utilization Review Contractor for each continued stay review:<br>(a) Changes to current DSM diagnosis;<br>(b) Justification for continued services at this level of care;<br>(c) Description of behavioral management interventions and critical incidents;<br>(d) Assessment of treatment progress related to admitting symptoms and identified treatment goals; |

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| | (e) List of current medications and rationale for medication changes, if applicable; and<br>(f) Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan.<br>(4) The clinical reviewer will complete the continued stay review process within two business days of receipt of complete information as described above and take one of the following actions:<br>(a) Request additional information as needed to complete the review, the provider must submit the requested information within five business days of the request for additional information.<br>(b) Authorize the continued stay for up to 90 days and generate notification to all appropriate parties if the continued stay meets the medical necessity criteria.<br>(c) Defer the case to a board-certified psychiatrist for review and determination if the continued stay does not meet the medical necessity criteria.<br>(5) The board-certified psychiatrist will complete the review and determination within four business days of receipt of the information from the clinical reviewer.<br>(6) After a denial, a new continued stay request may be submitted only if there is new clinical information. |
| Benefit Exclusion Criteria | Any one of the following criteria is sufficient for exclusion from this level of care:<br>(1) The youth exhibits suicidal or acute mood symptom(s)/thought disorder(s) which require a more intensive level of care.<br>(2) The youth has medical conditions or impairments that would prevent beneficial utilization of services.<br>(3) The primary problem is not psychiatric. It is a social, legal, or medical problem without a major concurrent psychiatric episode meeting criteria for this level of care or does not otherwise meet the SED and continued stay criteria.<br>(4) The admission is being used as an alternative to placement within the juvenile justice or child protective system or as an alternative to specialized schooling or as respite or as housing.<br>(5) The youth can be safely and effectively treated at a least intensive level of care. |
| Required Forms | Therapeutic Group Home Transfer Form<br>Emergency 72 hr TGH Payment Authorization Request (when applicable) |
| Additional Information | **Discharge Notification**<br>The discharge task must be completed in the Utilization Management portal within five business days of discharge.<br><br>For a youth that is transferring to a different TGH within the same provider company the provider must complete and submit a TGH Transfer Form, located at: CMHB Provider Forms. |

## Home Support Services (HSS)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 14

**Definition** Home Support Services provide high-quality, in-home behavioral health services for children and youth with serious emotional and behavioral needs. Services are provided in multiple setting and are focused on assisting youth and caregivers to develop skills necessary to safely remain in school, in the home, and in their community while focusing on their social, emotional, behavioral, and basic needs.

**Medical Necessity Criteria – HSS**

**Youth must meet the SED criteria as described in this manual and:**

(1) Youth six and older must have a moderate environmental stress in recovery environments as indicated by CASII Dimension IV.A. ~~4A~~ – level 3 or higher and/or a moderate functional impairment as indicated by CASII Dimension II level 3 or higher, or youth under the age of six must have an indication of stressors and vulnerabilities within the caregiver environment as indicated by a moderate score within Domain III B of the ECSII;

(2) The youth shall be assessed clinically, with clinical recommendation that identifies target skills and outcomes that will be achieved with HSS and community services; and

(3) The level of family commitment to services must be indicated by family agreement to at least two hours per week with HSS program.
(a) Families that are unwilling or unable to participate in treatment and/or services plan are ineligible.
(b) A week for HSS is Monday through Sunday.

**For discharge handoff services youth must meet the SED criteria and:**

(1) requirements (1) and (2) outlined above;
(2) the youth must be transitioning from residential treatment to community environment;
(3) treatment must be coordinated with the TGH or PRTF provider;
(4) the youth's family must be involved; and
(5) weekly contact with the family is required.

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | A prior authorization is not required. |
| Service Requirements | To be eligible for Medicaid reimbursement, the following minimum contacts and service requirements must be met: |

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| | (1) Be provided in multiple settings including home, school, and other community settings, as indicated by individual treatment plan;<br>(2) Be provided at frequency and length indicated by the individual treatment plan, with a minimum of eight units of face-to-face HSS services (two hours per week per family). Up to four of these units may be provided via telehealth. Skills building must be provided each week; and<br>(3) Include bi-weekly (every other week) face-to-face contact with the family by the clinical lead. Up to one meeting per month may be conducted via telehealth.<br>For requirements (2) and (3) face-to-face service delivery is preferred. Telehealth may be substituted if clinically indicated or if the youth does not have access to face-to-face services. Case notes must include reason, including documentation of attempts to identify local supports, if related to access.<br><br>The HSS provider must:<br>(1) Engage with the youth and caregivers in initial and continued psychoeducation related to the youth's diagnoses and/or behavioral health needs, as well as applicable intervention strategies.<br>(2) Work with the youth and caregivers to develop adaptive and emotional coping skills across settings, such as emotional regulation, problem solving, communication, conflict management, and decision making.<br>(3) Work with caregivers to help them acquire and use behavior management skills as indicated by the treatment plan. Examples include consistency and follow through, use of meaningful rewards and consequences, problem solving, praise and positive communication, conflict resolution, and the development of child supervision and monitoring plans.<br>(4) Work with caregivers to develop supportive and nurturing relationships with the youth that promote resiliency and wellness.<br>(5) Demonstrate competency in cognitive behavioral interventions, including assisting youth and caregivers in identifying underlying emotions and emotional triggers, and in developing cognitive flexibility, emotional regulation, and/or adaptive thinking patterns.<br>(6) Work with the youth and caregivers to identify non-adaptive interactional patterns and develop and implement family system interventions that increase youth and caregiver adaptive responses and functioning.<br>(7) Each HSS team must provide at least 75% of services in the home, school, or community setting(s).<br>(8) Administer and document the CASII or ECSII in each individualized treatment plan and 90-day treatment plan review. The treatment plan will include anchor points identified in the CASII or ECSII as areas of treatment focus.<br><br>The requirements outlined in (2) and (3) above are waived for the warm discharge hand-off period, during the warm discharge hand-off period the provider must meet all other requirements and have weekly contact with the family to be eligible for Medicaid reimbursement. |

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| Continued Stay Criteria | A continued stay request is not required, the youth must continue to meet admission criteria. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Any one of the following criteria will result in exclusion from this level of care:<br>(1) The home environment in which the service takes place presents a serious safety risk to the staff persons who would provide the service.<br>(2) The youth exhibits suicidal or acute mood symptoms/thought disorder which require a more intensive level of care.<br>(3) The youth has medical conditions or impairments that would prevent beneficial utilization of services.<br>(4) Introduction of this service would be duplicative of services that are already in place.<br>(5) The primary problem is not psychiatric. It is a social, legal, or medical problem without a major concurrent psychiatric episode meeting criterion for this level of care or does not otherwise meet the SED and continued stay criteria.<br>(6) The youth can be safely and effectively treated at a less intensive level of care. |
| Required Forms | Not applicable. |
| Additional Information | Frontier Community Differential: HSS rendered to youth residing in a frontier community are eligible to receive a frontier community differential, as described in ARM 37.87.1401.<br><br>Frontier counties: Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Carter, Chouteau, Custer, Daniels, Dawson, Fallon, Fergus, Garfield, Glacier, Golden Valley, Granite, Hill, Jefferson, Judith Basin, Liberty, Lincoln, Madison, McCone, Meagher, Mineral, Musselshell, Park, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Stillwater, Sweet Grass, Teton, Toole, Treasure, Valley, Wheatland, and Wibaux.<br>Non-frontier counties: Cascade, Deer Lodge, Flathead, Gallatin, Lake, Lewis and Clark, Missoula, Ravalli, Silver Bow, and Yellowstone. |

## Therapeutic Foster Care (TFC)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 14

**Definition** Therapeutic Foster Care Services are in-home therapeutic and family support services for youth living in a licensed therapeutic foster home environment. Services are focused on the reduction of behaviors that interfere with the youth's ability to function in the family and/or home community, facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care, and to support permanency or return to the legal guardian. The provider is available by phone or in-person to assist the youth and foster family during crisis.

Therapeutic Foster Care services include:

(a) Functional assessment of the youth and family system;
(b) Crisis planning and response;
(c) Behavioral coaching and training for the youth; and
(d) Behavioral coaching and training for the foster and natural family.

**Medical Necessity Criteria – TFC**

**Youth must meet the SED criteria as described in this manual and:**

(1) The youth exhibits behaviors related to the covered diagnosis that result in risk of out of home placement unless TFC services are provided.

(2) Less restrictive services are not available to the youth.

(3) The foster parent requires supportive services to safely manage the clinical symptoms of the youth in the current home environment.

(4) The youth is transitioning from an out-of-home placement to a community setting, and there is clinical evidence that less intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avoid the need to initiate or continue a more intensive level of care due to current risk to the youth or others.

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | A prior authorization is not required. |
| Service Requirements | After the initial 180 days of TFC the provider must document in the file of the youth all the following:<br>(1) Reassessment of the youth demonstrates the youth continues to meet the SED criteria. |

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| | (2) The foster parent continues to need support to improve their capacity to parent in order to address the emotional or behavioral needs of the youth as identified in the Individualized Treatment Plan (ITP).<br>(3) Services are rendered in a clinically appropriate manner and focused on the behavior of the youth and the parent/caregiver's need for support, guidance, and coaching.<br>(4) The youth or foster parent are engaged in services and are making documented progress towards goals, but maximum benefit has not yet been achieved AND withdrawing services would likely result in a decline in the youth and family's functioning, including the possibility of placement of the youth in a higher level of care.<br>(5) If the youth or foster parent are not progressing appropriately or if the condition of the youth has worsened, evidence of active, timely crisis intervention, re-evaluation and change of the ITP has occurred to address the current needs and needs to be documented in the monthly summaries that are required in rule.<br>(6) The symptoms or behaviors of the youth do not require a more intensive level of care but have demonstrated that they are severe enough that a less intensive level of service would be insufficient to successfully support the youth in the home setting. |
| Continued Stay Criteria | Not applicable. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Any one of the following criteria is sufficient for exclusion from this level of care.<br>(1) The youth exhibits suicidal or acute mood symptoms/thought disorder which require a more intensive level of care.<br>(2) The youth has medical conditions or impairments that would prevent beneficial utilization of services.<br>(3) Introduction of this service would be duplicative of services that are already in place.<br>(4) The primary problem is not psychiatric. It is a social, legal, or medical problem without a major concurrent psychiatric episode meeting criteria for this level of care or does not otherwise meet the SED and continued stay criteria.<br>(5) The youth can be safely and effectively treated at a less intensive level of care. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Therapeutic Foster Care Permanency (TFOC-P)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 14

**Definition** Therapeutic Foster Care Permanency Services are an intensive level of treatment for youth in a permanent therapeutic foster family placement. As with Home Support Services and Therapeutic Foster Care, services are focused on the reduction of behaviors that interfere with the youth's ability to function in the family and facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care. With this service, the foster parent(s) receive specialized behavioral training by a licensed mental health professional. The provider is available by phone or in person to assist the youth and family during crises. Therapeutic Foster Care-Permanency includes:

(a) Functional assessment of the youth and family system;
(b) Crisis planning and response;
(c) Behavioral coaching and training for the youth; and
(d) Behavioral coaching and training for the family.

**Medical Necessity Criteria – TFOC-P**

**Youth must meet the SED criteria as described in this manual and:**

(1) The SED symptoms of the youth are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health services;

(2) The youth exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if TFOC-P is not provided, or the youth is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting;

(3) The prognosis for treatment of the serious emotional disturbance of the youth at a less intensive level of care is very poor because the youth demonstrates three or more of the following due to the emotional disturbance or mental illness:

(a) Significantly impaired interpersonal or social functioning;
(b) Significantly impaired educational or occupational functioning;
(c) Impairment of judgment; or
(d) Poor impulse control;
(e) As a result of the serious emotional disturbance, the youth exhibits an inability to perform daily living activities in a developmentally appropriate manner;
(f) As a result of the emotional disturbance or mental illness, the youth

exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

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| Certificate of Need (CON) | A CON is not required |
| Prior Authorization | A prior authorization is not required |
| Service Requirements | After 180 days of TFOC-P the provider must document in the file of the youth the following:<br>(1) The youth must continue to meet all the admission criteria.<br>(2) The youth and family are engaged in treatment and making progress toward treatment goals.<br>(3) The symptoms of the youth do not require a more intensive level of care but have demonstrated they are severe enough that a less intensive level of care would be insufficient to meet treatment needs.<br>(4) Demonstrated and documented progress is being made on the comprehensive discharge plan. If changes are made to the discharge plan or date, the provider must give the rationale for the change. |
| Continued Stay Criteria | Not applicable. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Any one of the following criteria is sufficient for exclusion from this level of care.<br>(1) The youth exhibits suicidal or acute mood symptom(s)/thought disorder(s) which require a more intensive level of care.<br>(2) The youth has medical conditions or impairments that would prevent beneficial utilization of services.<br>(3) Introduction of this service would be duplicative of services that are already in place.<br>(4) The primary problem is not psychiatric. It is a social, legal, or medical problem without a major concurrent psychiatric episode meeting criteria for this level of care or does not otherwise meet the SED criteria.<br>(5) The youth can be safely and effectively treated at a less intensive level of care. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Comprehensive School and Community Treatment (CSCT)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 18

**Definition** Comprehensive School and Community Treatment is a mental health center service provided by a public school district. A Comprehensive School and Community treatment team includes a licensed or supervised in-training practitioner and up to two behavioral aides, who are assigned to a specific public school(s). Once admitted into the program, a youth may receive services at the school, the home, or in the community. Services are focused on improving the youth's functional level by facilitating the development of skills related to exhibiting appropriate behaviors in the school, home, and community settings. These youth typically require support through cueing or modeling of appropriate behavioral and life skills to utilize and apply learned skills in normalized school and community settings.

Comprehensive School and Community Treatment includes:

(a) Individual, Group and Family Therapy

(b) Behavioral and life skills training

**Medical Necessity Criteria – CSCT**

**Youth must meet the SED criteria as described in this manual and:**

(1) Youth six and older must have a moderate environmental stress in recovery environments as indicated by CASII Dimension IV.A. – level 3 or higher and/or a moderate functional impairment as indicated by CASII Dimension II level 3 or higher.

(2) Youth under the age of six must have an indication of stressors and vulnerabilities within the caregiver environment as indicated by a moderate score within Domain III B of the ECSII.

(3) A youth who does not meet the SED criteria may be referred to the CSCT program for brief intervention, assessment, and referral regardless of the diagnosis of the youth for up to 10 service days annually.

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| Certificate of Need (CON) | A CON is not required |
| Prior Authorization | Prior authorization is required for a CSCT team of one staff to provide over 120 service days/month, and/or for a CSCT team of two staff to provide over 240 service days/month. Providers may email CMHB CSCT Program Officer for authorization. |
| Service Requirements | (1) Each youth enrolled in the program must:<br>(a) Have an annual assessment as specified in Chapter 3 of this manual; and |

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| | (b) Have an individualized treatment plan in accordance with ARM 37.106.1916.<br>(2) The provider must administer and document the CASII or ECSII in each individualized treatment plan and 90-day treatment plan review. The treatment plan will include anchor points identified in the CASII or ECSII as areas of treatment focus.<br>(3) Face-to-face service delivery is preferred. Telehealth may be substituted if clinically indicated or if the youth does not have access to face-to-face services. Case notes must include reason, including documentation of attempts to identify local supports, if related to access. |
| Continued Stay Criteria | A continued stay is not required, the youth must continue to meet admission criteria. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Any one of the following criteria will result in the youth's exclusion from this level of care.<br>(1) The youth exhibits symptoms which require a more intensive level of care.<br>(2) The youth has medical conditions or impairments that would prevent beneficial utilization of services.<br>(3) Introduction of this service would be duplicative of services that are already in place.<br>(4) The primary problem is not psychiatric. It is a social, legal, or medical problem without a major concurrent psychiatric episode meeting criterion for this level of care or does not otherwise meet the SED and continued stay criteria.<br>(5) The youth can be safely and effectively treated at a less intensive level of care. |
| Required Forms | Not applicable. |
| Additional Information | **Frontier Community Differential:** CSCT rendered to youth attending school in a frontier community are eligible to receive a frontier community differential, as described in ARM 37.87.1803.<br><br>Frontier counties: Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Carter, Chouteau, Custer, Daniels, Dawson, Fallon, Fergus, Garfield, Glacier, Golden Valley, Granite, Hill, Jefferson, Judith Basin, Liberty, Lincoln, Madison, McCone, Meagher, Mineral, Musselshell, Park, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Stillwater, Sweet Grass, Teton, Toole, Treasure, Valley, Wheatland, and Wibaux.<br>Non-frontier counties: Cascade, Deer Lodge, Flathead, Gallatin, Lake, Lewis and Clark, Missoula, Ravalli, Silver Bow, and Yellowstone. |

## Day Treatment (Day TX)

Administrative Rules of Montana Title 37, Chapter 106, Subchapter 19

**Definition** Youth Day Treatment services are a set of mental health services provided in a specialized classroom setting that is not co-located in a public school. The educational component of the program is not paid for by Medicaid and must be provided through full collaboration with a public school district. A licensed therapist provides services at no more than one to twelve members. The services are focused on building skills for adaptive school and community functioning and reducing symptoms and behaviors that interfere with a youth's ability to participate in their education at a public school, to minimize need for more restrictive levels of care and to support return to a public school setting as soon as possible. Day Treatment includes:

(a) Individual, family, and group therapy
(b) Social and life skills training
(c) Therapeutic recreation services

**Medical Necessity Criteria – Day TX**

**Youth must meet the SED criteria as described in this manual.**

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| Certificate of Need (CON) | A CON is not required |
| Prior Authorization | Prior authorization is not required. |
| Service Requirements | See ARM 37.106.1936. |
| Continued Stay Criteria | Not applicable. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Intensive Outpatient Therapy (IOP)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 7
Administrative Rules of Montana Title 37, Chapter 106, Subchapter 19

**Definition** Intensive Outpatient Therapy (IOP) services provide weekly structured intensive mental health care to youth with serious emotional disturbance (SED) while allowing youth to safely remain in school, in the home, and in their community. Services are provided by a licensed Mental Health Center.

**Medical Necessity Criteria – IOP**

**Youth must meet SED criteria as described in this manual and:**

(1) The youth must have documented need for six or more hours of structured programming per week.

(2) The youth must require at least three or more different core services described below:

(a) Individual psychotherapy;
(b) Group psychotherapy;
(c) Family psychotherapy;
(d) Community-based psychiatric rehabilitation and support (CBPRS);
(e) Crisis services; and
(f) Care coordination.

(3) It is not required that each member receiving IOP services receive every service listed above. All medically necessary services must be provided and documented in the individualized treatment plan (ITP).

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | A prior authorization is not required. |
| Service Requirements | (1) Group therapy services may not have more than 10 members participating in the group.<br>(2) Services received must be documented clearly in the member's treatment file.<br>(3) Services delivered via telehealth are reimbursable when medically necessary and clinically appropriate for delivery via telemedicine.<br>(4) Service must be provided in accordance with all Administrative Rules of Montana and federal regulations.<br>(5) Providers billing the bundled rate must meet six or more service hours per week. Care coordination services can account for a maximum |

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| | of one hour per week of the six service hours.<br>(6) If the service hour requirements are not met the provider must unbundle and bill using the appropriate outpatient codes.<br>(7) Providers may not bill both a bundled rate AND applicable outpatient codes for any of the core services described.<br>(8) A billable day must be a minimum of 45 minutes of service.<br>(9) Care coordination is billable for a maximum of one hour per week. |
| Continued Stay Criteria | Not applicable. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Outpatient Therapy (OP)

Administrative Rules of Montana Title 37, Chapter 87

**Definition** Outpatient therapy services include individual, family, and group therapy in which diagnosis, assessment, psychotherapy, and related services are provided by a licensed mental health professional acting within the scope of the professional's license or a mental health center in-training mental health professional as defined at ARM 37.87.702(3).

**Medical Necessity Criteria – OP**

**For the first 24 patient sessions per state fiscal year:**

(1) The youth must have a recognized mental health diagnosis.

(2) Outpatient therapy services that do not count towards the 24 sessions are as follows:

(a) Psychiatric Diagnostic or evaluative interview procedures;
(b) Group psychotherapy;
(c) Outpatient psychotherapy with medication evaluation and management services;
(d) Pharmacological or medication management services;
(e) Central nervous system assessments/tests or psychological testing performed by a physician or psychologist;
(f) Outpatient therapy services provided as part of the CSCT service; and
(g) Psychotherapy crisis codes.

**For sessions in excess of 24 per state fiscal year, youth must meet the SED criteria as described in this manual and all the following:**

(1) A family driven Individualized Treatment Plan (ITP) has been formulated that identifies strength-based, achievable goals and measurable objectives that are directed toward the alleviation of the symptoms and/or causes that led to the treatment. The response of the youth to treatment has been regularly documented, and revisions in the ITP are consistent with the clinical needs of the youth.

(2) The youth and family, if applicable, have demonstrated investment in the therapeutic alliance and have agreed to the goals/objectives of the ITP.

(3) Progress toward treatment goals has occurred as evidenced by measurable reduction of symptoms or behaviors that indicate continued responsiveness to treatment.

(4) A discharge plan has been formulated and regularly reviewed and revised. It must identify specific target dates for achieving specific goals and define criteria for conclusion of treatment.

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | A prior authorization is not required. |
| Service Requirements | Any service requirements as described in ARM and federal regulations. |
| Continued Stay Criteria | For sessions in excess of 24 per state fiscal year, the mental health professional must document the youth meets the clinical guidelines. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Targeted Case Management (TCM)

Administrative Rules of Montana Title 37, Chapter 86, Subchapter 33
Administrative Rules of Montana Title 37, Chapter 87, Subchapter 8

**Definition** Targeted Case Management is the process of assessing needs, developing a service plan, coordinating services, and monitoring progress for the family system with an emphasis on the youth. Targeted Case Management assists, advocates, and empowers the family to help the youth obtain the necessary services to remain in school, in the home, and in their community while focusing on their social, emotional, behavioral, and basic needs.

Case management services are comprehensive and must include all requirements outlined in 42 CFR 440.169 and Administrative Rule Title 37, chapter 86, subchapter 33.

**Medical Necessity Criteria – TCM**

**Youth must meet the SED criteria as described in this manual and the parent or caregiver must give consent and agree to participate in TCM, and:**

(1) Within 14 days of admission, the youth and family or caregiver have been assessed and have documented need for case management based on:

(a) Complexity of youth and family service needs and/or interventions;
(b) Severity of the youth's behavioral health symptoms; or
(c) Strengths, preferences, and needs within family or caregiver capacity; and

(2) The youth and family or caregiver's needs have been assessed and documented that TCM services are necessary to maximize benefit and leverage resources from other systems in which the family or caregiver is involved, with an emphasis on natural supports.

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | A prior authorization is not required. |
| Service Requirements | Any service requirements as described in ARM listed above. |
| Continued Stay Criteria | The youth must meet the medical necessity criteria for TCM level of care as documented in updated treatment plans, recommendations of the treatment team, or progress notes of the systems or services the youth is receiving and maintained in the file of the youth. |

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| Continued Stay Review | The case management supervisor must verify in the file of the youth that each youth in services meet the above criteria. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Federal rule or Montana Medicaid prohibit the following activities to be billed as case management.<br>(1) Direct delivery of a medical, educational, social, or other service to which an eligible youth has been referred;<br>(2) Medicaid eligibility determination and redetermination activities which include outreach, application, and referral activities;<br>(3) Transportation services;<br>(4) The writing, recording, or entering of case notes in a case file; and<br>(5) Coordination of the investigation of any suspected abuse, neglect and/or exploitation cases.<br><br>**The case manager's role during crises:**<br>The case manager's function includes assisting the family in anticipating and describing the crises they may experience; as well as developing a crisis plan to address these crises. 42 CFR 441.18 (c) states targeted case management does not include direct service. As long as the crisis plan does not identify the case manager as the primary responder to the person's crisis, it is appropriate for the case manager to be available to assist the family in activating the resources they identified in the crisis plan.<br><br>**Frontier Community Differential:** Targeted case management services rendered to youth residing in a frontier community are eligible to receive a frontier community differential, as described in ARM 37.87.809.<br><br>Frontier counties: Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Carter, Chouteau, Custer, Daniels, Dawson, Fallon, Fergus, Garfield, Glacier, Golden Valley, Granite, Hill, Jefferson, Judith Basin, Liberty, Lincoln, Madison, McCone, Meagher, Mineral, Musselshell, Park, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Richland, Roosevelt, Rosebud, Sanders, Sheridan, Stillwater, Sweet Grass, Teton, Toole, Treasure, Valley, Wheatland, and Wibaux.<br><br>Non-frontier counties: Cascade, Deer Lodge, Flathead, Gallatin, Lake, Lewis and Clark, Missoula, Ravalli, Silver Bow, and Yellowstone. |

## Therapeutic Home Visit (THV)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 12 (Concurrent with PRTF)
Administrative Rules of Montana Title 37, Chapter 87, Subchapter 10 (Concurrent with TGH)

**Definition** A Therapeutic Home Visit is an opportunity to assess the ability of the youth to successfully transition to a less restrictive level of care. 14 days is the maximum benefit allowed per youth per state fiscal year (July 1-June 30).

**Medical Necessity Criteria – THV**

**The youth must be receiving services in a Psychiatric Residential Treatment Facility (PRTF) or Therapeutic Group Home (TGH).**

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | A prior authorization is required for each stay that will exceed three patient days per visit. The department must receive the request for the additional day(s) no earlier than 10 business days and no later than five business days prior to the scheduled THV. Requests received earlier than 10 days prior to the scheduled THV will be technically denied. Computing time for prior authorization requests includes weekends and holidays. If a deadline falls on a weekend or holiday the deadline is the next business day. If a request is received after the authorized time period has expired, the request will be considered from the date received by the department. The department cannot retroactively authorize days if a THV request is received late.<br>(1) The following information must be submitted for a prior authorization for days that exceed three patient days per visit:<br>(a) Demonstrated progress toward identified treatment goals;<br>(b) How the THV supports a therapeutic plan to transition the youth to a less restrictive level of care;<br>(c) How the youth has been prepared for the THV evidenced by a written crisis plan and a written plan for provider contact with the youth and legal representative during the visit; and<br>(d) A viable discharge plan.<br>(2) The clinical reviewer will complete the review upon receipt of complete information as described above and take one of the following actions:<br>(a) Request additional information as needed to complete the review, the provider must submit the requested information before an authorization can be issued.<br>(b) Authorize the request and generate notification to all appropriate parties if the request meets the criteria.<br>(3) If unexpected circumstances prevent the youth from returning from the THV within the three-day timeframe, the department may consider requests for prior authorization for days which exceed three patient days. A provider must submit the request for prior authorization no later than one business day prior to the end of the three patient days or the time specified with |

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| | subsequent authorizations. |
| Service Requirements | (1) The plan of care for the youth must document the medical need for therapeutic home visits as part of a therapeutic plan to transition the youth to a less restrictive level of care.<br>(2) The provider must document staff contact and youth achievements or regressions during the following the therapeutic home visit. |
| Continued Stay Criteria | Not applicable. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Community Based Psychiatric Rehabilitation and Support Services (CBPRS)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 7

**Definition** Community-Based Psychiatric Rehabilitation and Support (CBPRS) means additional, one-to-one, intensive short-term behavior management and stabilization services in home, school, or community settings. They are for youth receiving mental health center services but failing to progress and at risk of out of home or residential placement; or for youth under six at risk of removal from their current setting. The purpose of CBPRS services is to "reduce disability" and "restore function."

**Medical Necessity Criteria – CBPRS**

**Youth must meet the SED criteria as described in this manual.**

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | A prior authorization is not required. |
| Service Requirements | (1) CBPRS may only be provided when a youth is receiving other mental health services. A current treatment plan must include the CBPRS rehabilitation goals for the youth that address the primary mental health needs of the youth. Daily progress notes must include time in and time out.<br>(2) CBPRS group services may only be provided:<br>(a) Up to a maximum of four hours of group per day;<br>(b) Up to a maximum of eight youth per group; and<br>(c) Up to a staff ratio of four youth to one staff.<br>(3) Community-based psychiatric rehabilitation and support may include the following services:<br>(a) Evaluation and assessment of symptomatic, behavioral, social, and environmental barriers;<br>(b) Assisting the youth to develop communication skills, self-management of psychiatric symptoms, and the social networks necessary to minimize social isolation and increase opportunities for a socially integrated life;<br>(c) Assisting the youth to develop daily living skills and behaviors necessary for maintenance of relationships, an appropriate education, and productive leisure and social activities; and<br>(d) Immediate intervention in a crisis situation to refer the youth to necessary and appropriate care and treatment.<br>(4) Community-based psychiatric rehabilitation and support does not include the following:<br>(a) Interventions provided during day treatment or partial hospitalization program hours, or if a youth is enrolled in CSCT during school hours;<br>(b) Interventions provided in a hospital, therapeutic group home, or residential treatment facility; |

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| | (c) Interventions provided by staff of group homes;<br>(d) Case planning activities, including attending meetings, completing paperwork and other documentation requirements, traveling to and from the home of the youth;<br>(e) Therapeutic interventions by licensed practitioners; and<br>(f) Activities which are purely recreational, instructional, or vocational in nature.<br>(5) Face-to-face service delivery is preferred. Telehealth may be substituted if clinically indicated or if the youth does not have access to face-to-face services. Case notes must include reason, including documentation of attempts to identify local supports, if related to access. |
| Continued Stay Criteria | Not applicable. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Extraordinary Needs Aide (ENA)

Administrative Rules of Montana Title 37, Chapter 87, Subchapter 10

**Definition** Extraordinary Needs Aide (ENA) services are additional, one-to- one, face-to-face, intensive short-term behavior management and stabilization services provided in the Therapeutic Group Home (TGH). ENA services are provided for youth who exhibit extreme behaviors that cannot be managed by regular staffing.

**Medical Necessity Criteria – ENA**

**Youth must meet the SED criteria as described in this manual and:**

(1) Exhibit extreme behaviors that cannot be managed by the TGH staffing required by licensure ARM 37.97.903.
(2) The extreme behaviors of the youth are current, moderately severe, and consist of documented incidents that are symptoms of the SED of the youth.
(3) The behaviors are either frequent in occurrence, or at risk of becoming a serious occurrence, and include one or more of the following behaviors:
(a) Harming self or others;
(b) Destruction of property; or
(c) A pattern of frequent extreme physical outbursts.

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| Certificate of Need (CON) | A CON is not required |
| Prior Authorization | A prior authorization is not required. |
| Service Requirement | (1) ENA must provide a one-to-one staffing ratio<br>(2) Daily progress notes must include time in and time out<br>(3) ENA staff must be in addition to TGH staff and may not be used to supplant the staffing requirements in ARM 37.97.903. |
| Continued Stay Criteria | (1) The youth must continue to meet admission criteria; and<br>(2) Demonstrate progress towards identified treatment goals and the reasonable likelihood of continued progress; and<br>(3) Demonstrated and documented progress is being made to implement an adequate transition plan to regular staffing and there is clinical rationale for any recommended changes in the transition plan or anticipated transition date. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

## Genetics Testing for Children's Mental Health

Administrative Rules of Montana Title 37, Chapter 12

**Definition** Genetics Testing is defined as lab tests used to determine if a youth is at risk for a mental health condition. Mental health genetic tests also may inform a youth's response to a certain drug or which dose to use.

**Medical Necessity Criteria – Genetics Testing**

**Youth must meet the SED criteria as described in this manual and:**

(1) The youth displays clinical feature or is at direct risk of inheriting a gene so that testing is necessary to improve clinical outcomes of neuropsychiatric medication.

(2) Documented previous medication failures and intent to alter medication course consistent with test results. Youth must have failed or currently be failing on at least one neuropsychiatric medication.

(3) Results of test will directly impact treatment being delivered to the patient.

(4) Documentation of risk and clinical need must include a comprehensive history, physical examination, and completion of conventional diagnostic studies.

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| Certificate of Need (CON) | A CON is not required. |
| Prior Authorization | **A prior authorization is required.**<br>(1) To request prior authorization for mental health genetics testing, the lab or physician must submit a prior authorization request to the Department's Utilization Review Contractor with documentation that demonstrates the medical need for the service.<br>(2) The request must include:<br>(a) Documented clinical features indicating risk of inheriting the mutation in question.<br>(b) Documented previous medication failures.<br>(c) Comprehensive history of the youth and physical examination.<br>(3) The clinical reviewer will complete the review for prior authorization upon receipt of complete information as described above and take one of the following actions:<br>(a) Request additional information as needed to complete the review, the provider must submit the requested information before an authorization can be issued. |

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| | (b) Authorize the request and generate notification to all appropriate parties if the request meets the medical necessity criteria and generate a prior authorization number for billing.<br>(c) Deny the request and generate notification. |
| Service Requirements | Genetics testing must follow all relevant Montana Medicaid rules. The prior authorization number must be present on the lab's claim for payment. |
| Continued Stay Criteria | Not applicable. |
| Continued Stay Review | Not applicable. |
| Benefit Exclusion Criteria | Not applicable. |
| Required Forms | Not applicable. |
| Additional Information | Not applicable. |

# Chapter 4 – Determinations

**Upon completion of either the prior authorization or the continued stay review, one of the determinations below will be applied.**

## Authorization

An authorization determination indicates that the utilization review resulted in approval or partial approval/denial of all provider requested services and/or services units.

## Pending Authorization for Request for Information (RFI)

An authorization that is pended for a Request for Information indicates the clinical reviewer or psychiatrist has requested additional information from the provider that is necessary in order to complete the review.

## Denial

When a request for authorization of payment does not meet the applicable criteria to justify Medicaid payment for the service requested the request will be denied. Adverse determinations may be appealed according to the reconsideration and/or appeal processes.

A psychiatrist is the only party qualified who may issue a denial for:

(a) Psychiatric Residential Treatment Facilities; and
(b) Psychiatric Residential Treatment Facilities - AS.

A denial may be issued with additional days authorized for payment, specifically:

(a) Denying a prior authorization request with "*approval for less than requested days*" for specific clinical reasons; OR
(b) Denying a continued stay authorization request with "*approval for additional days to complete discharge planning.*"

## Technical Denial

When an adverse determination is based on procedural issues and not on medical necessity criteria, the result will be a technical denial. Technical denials can be overturned by CMHB only for reasons provided for in Administrative Rule of Montana.

## Reconsideration Review Process for Children's Mental Health Services Requiring Prior Authorization and Continued Stay

A reconsideration review provides the parents/legal representatives, authorized representative, or the provider an opportunity for further clinical review if they believe there has been an adverse action regarding a denial determination.

**There are two types of reconsideration reviews:**

***Peer-to-Peer***: A Peer-to-Peer Review is a telephonic review between an advocating clinician, chosen by either the parents/legal representative or the authorized representative, and the physician reviewer who rendered the adverse determination.

(1) The Peer-to-Peer Review is based upon the original clinical documentation and may consider clarification or updates.

(2) The Peer-to-Peer Review must be:
(a) Requested within 10 business days of the adverse determination date; and
(b) Scheduled by the physician reviewer within five business days of the request.

***Desk Review***: A Desk Review may be requested in lieu of a Peer-to-Peer review or to provide a second opinion if the Peer-to-Peer Review results in an adverse determination. It must be provided by a licensed psychiatrist who did not issue the initial or a Peer-to-Peer determination.

(1) The Desk Review is based upon the original clinical documentation and any additional supporting documentation.

(2) The Desk Review must be:
(a) Requested within 15 business days of the most recent adverse determination date; and
(b) Performed by the physician within five business days of the written request and supporting documentation.

The parents/legal representative, authorized representative, or provider must submit a written request to the Utilization Review Contractor for this reconsideration review that states which review is being requested and naming an advocating physician. Further instructions pertaining to how to request a review are in the determination letter sent by the department or the Utilization Review Contractor. If new clinical information becomes available after a denial of a reconsideration review for services which are prior authorized by the Utilization Review Contractor, a provider may submit a new prior authorization to the Utilization Review Contractor, based on the

new clinical information.

# Chapter 5 – The Appeal Process

## Administrative Review/Fair Hearing

### Administrative Review/Fair Hearing Process

A medical assistance provider who is aggrieved by an adverse action of the Department may request an administrative review. The request must be in writing, must state in detail the provider's objections, and must include any substantiating documents and information which the provider wishes the Department to consider in the administrative review. The request for administrative review must be received by the Department within 30 days of mailing of the Department's or its contractors' written determination.

Complete information about administrative reviews and fair hearings is found in Administrative Rule of Montana Title 37, Chapter 5.

### Claims Denial Administrative Reviews

The provider has the right to appeal a claim denial.

Prior to requesting an administrative review for denied claims, all administrative remedies available must be exhausted. For denied claims, those remedies may include:

(a) Researching the denial codes;
(b) Correcting errors and omissions; and
(c) Resubmitting the claims.

Assistance for providers with claims problems is available through the state's fiscal agent's provider relations program by calling (800)624-3958 (in/out of state), (406)442-1837 (Helena). If the fiscal agent is unable to assist the provider, the Program Officer in the CMHB responsible for the service affected may be contacted.

Administrative reviews for children's mental health services may be submitted to the Children's Mental Health Bureau via fax at (406)444-5913 or mailed to 111 N. Sanders Street, Helena, MT, 59602. Please contact the Children's Mental Health Bureau's Program Officer for alternative options for submitting.

# Chapter 6 – Reviews

## Retrospective Reviews/Quality Audit Reviews

The department or the Utilization Review Contractor may perform retrospective clinical record reviews for two purposes:

(1) To determine necessity of a provided service; or
(2) As requested by the provider to establish the medical necessity for payment when the youth has become Medicaid eligible retroactively or the provider has not enrolled in Montana Medicaid prior to the admission of the youth.

Retrospective reviews may be used to verify any of the following:

(1) There is sufficient evidence of medical necessity for payment;
(2) The youth is receiving active and appropriate treatment consistent with standards of practice for the diagnosis, age, and circumstances of the youth; or
(3) The criteria for having a serious emotional disturbance (SED) have been met.

### Retrospective Reviews and Quality Audit Reviews by the Department

The department or the Utilization Review Contractor will notify the provider by letter of the following;

(1) The purpose of the review; and
(2) If records are requested, what records are required and the specific time period within which the full medical record is due to the Department or the Utilization Review Contractor.

Quality audit reviews are conducted as determined by the department.

### Retrospective Reviews Requested by the Provider

(1) A provider may request a retrospective review when the youth becomes Medicaid eligible after the admission to the facility or program or when the provider has not enrolled in Montana Medicaid prior to the admission of the youth:
    (a) Within 14 days after Montana Medicaid is established if prior to the discharge of the youth.
    (b) Within 90 days after Montana Medicaid is established after the youth has discharged.

(2) A provider must submit a prior authorization request to the Utilization Review Contractor which includes:

(a) Documentation that the youth met medical necessity criteria; and
(b) A certificate of need; if applicable.

## Sanctions

The department or the Utilization Review Contractor will provide written notification of deficiencies identified and may require a corrective action plan or impose sanctions based on review recommendations. If the provider fails to correct the deficiencies identified in the written notification, the department may impose sanctions. The administrative rules which govern Medicaid provider sanctions are in the Administrative Rules of Montana, Title 37, chapter 85, subchapter 5.

# Chapter 7 – Notifications

Following a review process, the department or the Utilization Review Contractor will send a letter with the determination to the parent, legal representative, or authorized representative, and the provider. The letter will contain the rationale for the determination and provide appeal information if there is a right to a fair hearing.

## Formal Notification

Formal notification is sent to the parent/legal representative and/or the provider, via the U.S. Postal Service.

**Notification for technical denials will include**:

(a) Dates of service that are denied payment due to non-compliance with procedure;
(b) References to applicable regulations governing the review process;
(c) An explanation of the right, if any, to request an administrative review/fair hearing; and
(d) Address and fax number of CMHB to request an administrative review, if applicable.

**Notification for clinical denial determinations will include:**

(a) The date or dates of service that are denied payment because the service requested did not conform with professional standards, lacked medical necessity based on the criteria, or was provided in an inappropriate setting;
(b) Case-specific denial rationale;
(c) Date of notice of the denial determination, which is the mailing date;
(d) An explanation of the right to request a reconsideration review, and/or an administrative review/fair hearing;
(e) Address and fax number of the department or the Utilization Review Contractor to request a reconsideration review; and
(f) Address and fax number of CMHB to request an administrative review.

## Confidentiality

It is the policy of the department of Public Health and Human Services to comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). Information is exchanged in accordance with all applicable federal and state laws and regulations, as well as with the ethical and professional standards of the professions involved in conducting utilization management (UM) activities. These confidentiality policies govern all forms of information about beneficiaries, including written records, electronic records, facsimile mail, and

electronic mail. The above- described policy is applied to all aspects of the UM process.