



DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Child and Family Services Division Health Care Oversight and Coordination Plan

CFSP 2025-2029: Updated June 2025



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General Information

Montana's contact for the 2025 – 2029 Child and Family Services Report (CFSP) and subsequent Annual Progress and Service Report (APSR) is:

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The final document is formatted so it is accessible to individuals with visual impairments per Americans with Disabilities Act requirements.

Health Care Oversight and Coordination Plan

Department of Public Health and Human Services (DPHHS) Child and Family Services Division (CFSD) continues to use the existing Montana Medicaid schedule for initial and follow-up health screenings in conjunction with the Administrative Rule in Montana (ARM) that requires all youth entering foster care receive an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening within 30 days. If any mental health or dental needs are identified during this EPSDT screening, these services are eligible for Medicaid payment. Furthermore, CFSD policy states that any child "should be examined by a physician when there is reason to believe the child is a victim of serious physical or sexual abuse, has been exposed to a drug lab, or there is reason to believe the child may have drugs in their system due to actions by the parent." This policy will continue to be evaluated to determine if changes or enhancements should be made in the future.

CFSD partnered with the DPHHS Behavioral Health and Developmental Disabilities (BHDD), Children's Mental Health Bureau (CMHB), and Developmental Disability Program Bureau (DDPB) to create procedures and protocols to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medical fragile conditions, or developmental disabilities. In addition, these protocols help ensure foster care children are not placed in non-family settings because of inappropriate diagnosis.

CFSD current policy requires that not only children with substantiated abuse and/or neglect allegations, but also all children being served by CFSD in an in-home or out-of-home safety plan be referred for a Part C Screening. By making these screenings universal for the foster care population, more children with developmental disabilities, whether related to emotional trauma or cognitively based, will access entitlement services that will improve the well-being of the child. CFSD continues to partner with ECFSD to identify barriers to making Part C referrals and barriers to ensuring comprehensive screening for children.

CFSD will continue to work with the Medicaid Division to obtain ongoing reports on foster children that list the health physical, mental, and dental health needs identified through required screenings; as well as the treatment and services received.

CFSD analyzed the use of Child Adult Protection System (CAPS) and determined that the Medicaid system data is far superior to anything that could be captured by CFSD workers; therefore, moving forward, the goal continues to be developing efficient processes that allow the various computer systems to share information in an efficient manner as new DPHHS systems are constructed and completed. As CFSD works to replace the current Comprehensive Child Welfare Information System (CCWIS) i.e. CAPS, opportunities to include an interface with the BHDD, CMHB, and DDPB, system will be explored as applicable. CFSD continues to work with the state's Medicaid program to find ways to use this system more efficiently to develop an electronic health record for all foster youth.

CFSD continues to improve the well-being outcomes of foster youth by enhancing supervisor training discussed throughout the CFSP to ensure supervisors are more skilled in assisting the less experienced workforce to effectively connect treatment and case plans to screenings and assessments for children on their caseloads.

In 2017, the state legislature passed a bill requiring children in foster care to be enrolled in the state's Medicaid Passport to Health Program. This program includes medical homes for its patients. CFSD and Medicaid staff have worked over the last two years to address implementation issues related to children changing primary providers when they move from one area of the state to another. As foster youth become fully integrated into this program, this will provide enhanced opportunities for foster youth's medical records to be more readily available for review within the Medicaid system and

other physical and mental health providers, is an area that CFSD will work towards in the five-year cycle of the CFSP.

CFSD does not have sufficient resources to establish a medical home for every child without the Medicaid Division's continued support and involvement. Also, as the state's new CCWIS system continues to be developed and opportunities for effective interfaces within electronic record systems will continue to be explored. CFSD continues to work with the Medicaid Division on implementation of medical homes for every child in care, by continuing to support Foster Child Health Programs. The program facilitates a public health nurse supporting foster and kinship families meeting the medical and dental needs of children when placed in foster care. It was recognized as a promising practice by American Psychological Association's Society for Child and Family Policy & Practice. Currently, the program is implemented in four counties:

- Missoula (City: Missoula)
- Cascade (City: Great Falls)
- Yellowstone (City: Billings)
- Dawson (City: Glendive)

In addition, the Health Resources Division has a Behavioral Pharmacy Management Program, which meets monthly to review the use of psychotropic medications for all children receiving Medicaid. The committee reviews the types of medications used and the number of children receiving the medication. The committee also reviews any case that is outside the preferred recommended usage for that medication. These may include dosages above the recommended dosage, use of 2 or more medications of the same class of drug, use of 2 or more medications of different classes within the same time frame, and multiple prescribers for the same client. This committee will then provide the prescriber with a finding of their concerns and educational material that relate to the specified issue. This service has been greatly expanded for foster children in the past year, as described in the following proposal:

Through its various contractors, Mountain-Pacific Innovating Better Health (MPIBH) manages pharmaceutical services for CFSD Medicaid recipients through the Drug Utilization Review (DUR) and administration of the Drug Utilization Review Board, Formulary Management, Prior Authorization (PA), and Pharmacy Case Management (PCM). These contracted services share information about recipient drug use with providers and restrict utilization of some medications or therapeutic categories through benefit-design implementation. MPIBH has been providing DUR and Prior Authorization services to the Department for nearly 20 years. The PCM, the newest addition to services, was piloted to Montana Medicaid in 2002 and fully implemented in 2003. Initially the program focused on high utilizers of Medicaid services and patients with polypharmacy. DPHHS is very interested in expanding this program to help curb the huge increases in pharmacy costs while maintaining the clinical integrity of the provider community.

CFSD contracted Montana Chafee Foster Care Independence Program (MCFICIP) providers, who have been trained on these requirements at mandatory training. The providers submit service logs documenting that this requirement has been met and note whether the child exercised his or her option to execute a health care proxy. This will be a standing agenda item for the annual business process meeting with the MCFICIP contractors.

Psychotropic Medications for Youth in Foster Care

CFSD has become increasingly concerned about the safe, appropriate, and effective use of psychotropic medications among children in foster care. A sixteen-state study revealed foster children were prescribed antipsychotics at nine times the rate of other Medicaid recipients. While medications can be an important component of treatment, strengthened oversight of psychotropic medication use is necessary to responsibly and effectively attend to the clinical needs of children who have experienced maltreatment. A glaring area of vulnerability for foster children is polypharmacy, which may lead to significant drug interactions. Additionally, although clinically effective, psychotropic medications are highly potent agents with the potential for significant adverse effects such as metabolic syndrome. Metabolic syndrome is known to increase the risk of developing cardiovascular disease, particularly heart failure, and diabetes. The purpose of these requirements is to ensure that children in foster care receive high-quality, coordinated medical services, including appropriate medication, even as their placements change.

The purpose of the project between CFSD, Montana Medicaid, and MPIBH is to evaluate the use of psychotropic medications in Montana Medicaid children, with a focus on foster care children, using a Clinical Pharmacist, to evaluate and improve the prescribing and monitoring of psychotropic medication through educational and clinical interventions.

MPIBH review process is that they receive a list of all children under 18 Years of age that are in the custody of CFSD for the month requested. The list generally has about 1500-2000 children. Placements include:

- Family Foster Care
- Kinship Foster Care
- Therapeutic Group Home (TGH)
- Psychiatric Residential Treatment Center (PRTF)
- Foster Care Group Homes MPIBH addresses psychotropic medication utilization in foster children via a contract with the Montana Healthcare Programs. Using PCM the program evaluates the prescribing and monitoring of psychotropic medications through educational and clinical interventions.

MPQH has also created a secondary review program that goes hand in hand with our foster care psychotropic program. This program requires all children under 6 years of age prescribed an atypical antipsychotic by a non-fellowship trained pediatric psychiatrist to have a consent form and baseline laboratory requirements prior to initiating the medication and receiving approval. The provider and legal guardian must review the medication together, the side-effects, and both consent before initiating the medication, as well as obtain the necessary laboratory monitoring requirements. They must also continue to follow continued laboratory monitoring requirements, as well as form renewal. This process enables oversight of prescribing, as well as medication and lab monitoring, education, and compliance with the providers. CFSD currently has around 90 children in this program and all these interventions are also followed by case management staff.

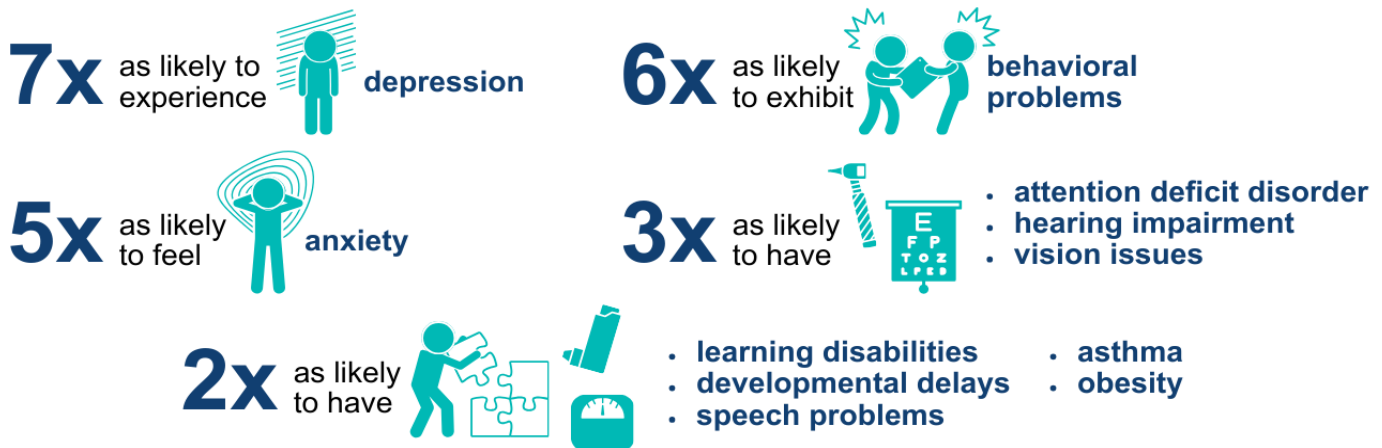
The contract with MPIBH and the work done by their staff continues to be very well received by CFSD staff and clinicians across the state and is considered one of the most impactful components of the Health Care Oversight & Coordination Plan.

MPIBH Evaluation of the Program (FFY2024)

The Clinical Issue

In November 2011, state directors received a letter from the U.S. Department of Health and Human Services (HHS) addressing the concern about the safe, appropriate and effective use of psychotropic medications among children in foster care. A 16-state study revealed foster children were prescribed antipsychotics at nine times the rate of other Montana Healthcare Program members.¹

National studies have shown children in foster care are at a significantly higher risk of developing mental and physical health conditions, including²:



Reference: Turney, K., & Wildeman, C. (2016). *Mental and Physical Health of Children in Foster Care*. *Pediatrics*, 138(5), 2016-1118.

Although clinically effective, psychotropic medications are highly potent agents with the potential for significant adverse effects such as metabolic syndrome. Metabolic syndrome is known to increase the risk of developing cardiovascular disease, particularly heart failure and diabetes. Metabolic lab testing (i.e., HbA1c, fasting glucose, lipid panel) for any child on an atypical antipsychotic can help identify children who may be at risk for metabolic syndrome, leading to clinical interventions that may decrease long-term risks (e.g., diabetes, heart disease, obesity, joint problems) and reduce harm associated with these medications.

While medications can be an important component of treatment, strengthened oversight of psychotropic medication use is necessary to monitor the clinical needs of this vulnerable population.

The Response

The foster care review and psychotropic drug oversight program was born out of the need to evaluate the use of psychotropic medications in Montana Health Care Programs' children, with a focus on foster care children. Through this program, we evaluate and improve the prescribing and monitoring of psychotropic medications through educational and clinical interventions.

With the expertise of case management (CM) pharmacists, we ensure children in foster care receive high-quality, coordinated medical services, even as their placements change. Monthly claims are used to identify the number and type of psychotropic medications being prescribed for children in foster care 18 years of age and under. We analyze their psychotropic medication to ensure the following medication-related problems are reviewed:

- Diagnosis/indication
- U.S. Food and Drug Administration (FDA)-approved dosing
- Medication compliance
- Lowest effective dose
- Appropriate lab monitoring
- Drug-drug interactions
- Medication misuse/abuse
- Polypharmacy
- Multiple pharmacies/physicians

Claims are further evaluated to ensure foster children are receiving psychotherapy and attending annual well-child visits with their primary care providers. Well-child visits and psychotherapy are critical to successful clinical outcomes of foster children on psychotropic regimens.

The Importance of Routine Atypical Antipsychotic Metabolic Syndrome Lab Monitoring

Psychotropic medications are clinically effective; however, they are also highly potent and can potentially cause significant adverse effects. One known adverse effect is metabolic syndrome, which can increase the risk for cardiovascular disease, especially diabetes and heart failure. Metabolic lab testing (HbA1c/fasting glucose and lipid panel) can help identify children who may be at risk for metabolic syndrome because of their atypical antipsychotic medication. Identifying at-risk children leads to clinical interventions to help avoid long-term risks such as diabetes, heart disease, obesity and joint problems. Negative metabolic consequences, including weight gain and cardiometabolic abnormalities (e.g., central obesity, insulin resistance, dyslipidemia, systemic inflammation), can affect up to 60% of patients taking an atypical antipsychotic, with children having the highest risk.³ Guidelines addressing the frequency of monitoring vary, but the consensus is that baseline and ongoing fasting glucose/HgbA1c and lipid panel labs should be completed. See Table 1.1 below.^{4,5} Our CM pharmacists review claims databases to ensure foster children taking an atypical antipsychotic medication have current metabolic monitoring.

Table 1.1 Metabolic Syndrome Monitoring Recommendations for Pediatric Patients on Atypical Antipsychotics^{4,5}

Metabolic Syndrome Monitoring Recommendations for Pediatric Patients on Atypical Antipsychotics							
Parameter Monitored	Initiation				Ongoing		
	Baseline	4-Weeks	8-Weeks	12-Weeks	Quarterly	6-Months	Annually
Personal/family history	X						X
Weight and body mass index (BMI)	X	X	X	X	X		
Waist circumference	X			X			X
Blood pressure	X			X			X
Fasting plasma glucose/HbA1c	X			X		X	X
Fasting lipid profile	X			X		X	X

The Importance of Psychotherapy

In addition to metabolic syndrome lab monitoring, our CM pharmacists ensure foster children are involved in routine psychotherapy. Psychotherapy is an integral part of mental health treatment and can be beneficial in the treatment of psychiatric disorders, behaviors, home and/or school relationships and family situations. In children and adolescents aged 4 to 18 years of age, the average treated child was better adjusted after psychotherapy than 79% of children who were not treated.⁶ Psychotherapy can be used alone or in conjunction with medication.

The Importance of Annual Routine Well-Child Visits

Finally, profiles are reviewed to ensure foster children are receiving annual routine well-child visits with their primary care providers. Well-child visits are a critical component of health care for children and adolescents. It is important for children to see their primary care providers to track growth and development milestones, obtain scheduled vaccinations and discuss concerns about the child's health. The American Academy of Pediatrics recommends annual routine well-child visits for children and adolescents aged 3 to 21 years of age.⁷

Due to research demonstrating the high-risk for other co-morbid disease states (e.g., asthma, obesity), as well as the inherent increased risks associated with atypical antipsychotics, (e.g., metabolic syndrome, hyperprolactinemia [in some atypical antipsychotic but not all]), we expanded our CM reviews to include monitoring for a diagnosis of obesity, asthma, hyperlipidemia or hyperprolactinemia.

Activities and Interventions

Foster care members are identified for this program by evaluating claims data and identifying which members meet one or more of the following criteria:

- One or more antipsychotic medication(s).
- Two or more atypical antipsychotic medications.
- Three or more psychotropic medications.
- Under 9 years of age on an atypical antipsychotic medication.
- One or more attention-deficit/hyperactivity disorder (ADHD) medication(s).
- No well-child visit within 365 days.
- More than two prescribers of psychotropic medications.
- Atypical antipsychotic with diagnosis of obesity.
- Atypical antipsychotic with diagnosis of hyperlipidemia.
- Atypical antipsychotic with diagnosis of hyperprolactinemia.
- Diagnosis of asthma and frequent albuterol fills.

In calendar year (CY) 2024, 665 clinical reviews were performed on 308 children. Of the 665 clinical reviews, 37% (249) triggered interventions with providers regarding issues on the member's profile. Interventions included recommendations made to providers for psychotropic prescriptions, diagnosis and medication-related concerns. Psychotropic prescription-related review selection criteria included:

- ADHD medication
- Three or more psychotropic medications
- One or more antipsychotics
- Two or more atypical antipsychotics
- Younger than 9 years old on an atypical antipsychotic

Diagnosis-related review selection criteria include asthma, obesity/overweight, hyperlipidemia and hyperprolactinemia. Medication-related issue interventions addressed:

- Adherence
- Adverse reaction
- Diagnosis/indication
- Dose/frequency/duration
- Duplicate therapy
- Polypharmacy
- Indication
- Appropriate lab monitoring

- Drug-drug interactions
- Medication misuse/abuse
- Overutilization concerns
- Multiple pharmacies/physicians

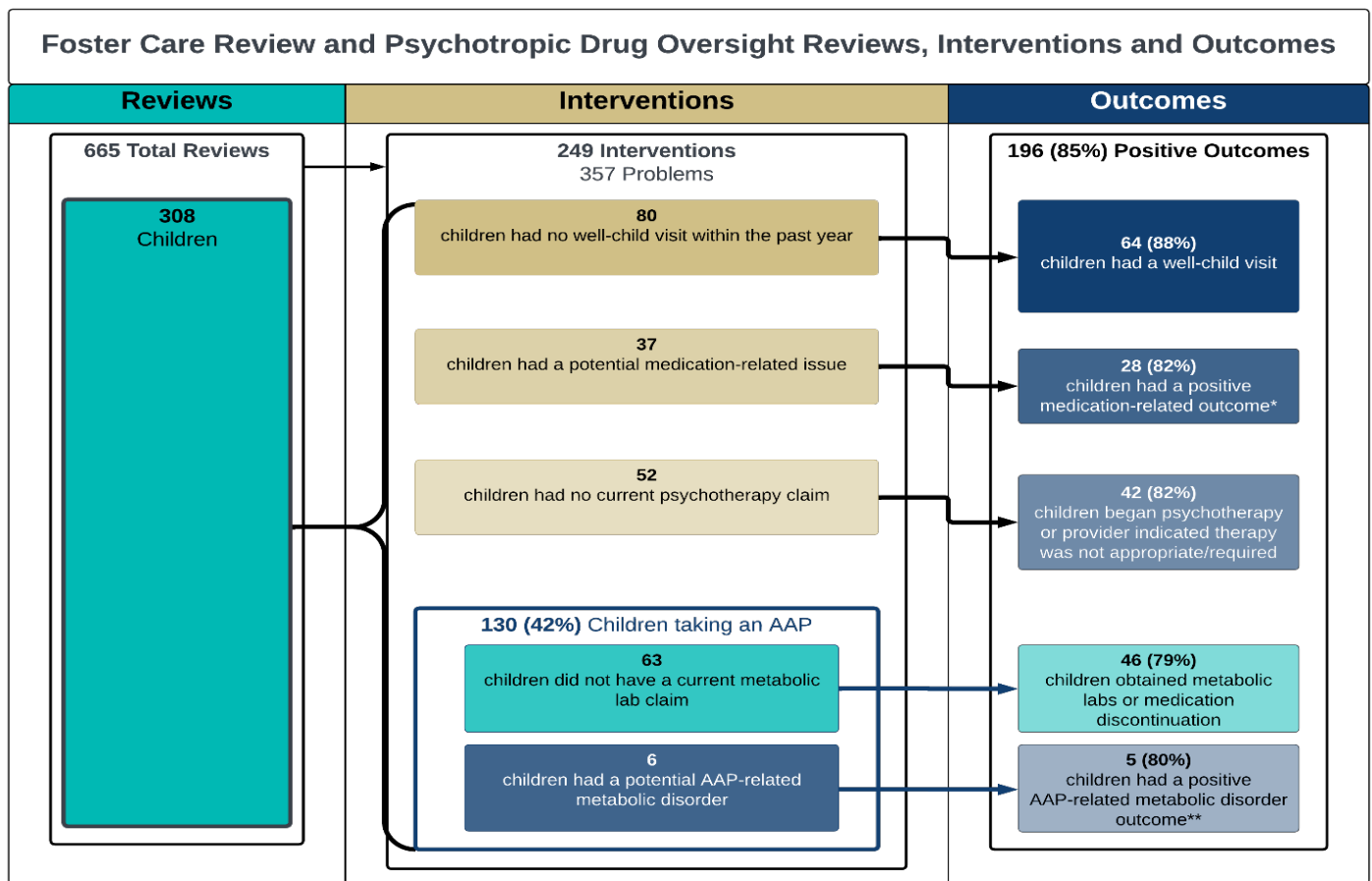
Outcomes

In CY 2024, 308 individual foster child cases were reviewed. Of those, 42% (130) were taking an atypical antipsychotic. Program summary and outcomes are represented in Figure 1.1. Program outcomes were calculated on completion of annual metabolic labs, medication discontinuation, current psychotherapy, annual well-child visits, provider accepting the suggested medication change (positive medication-related outcome, atypical antipsychotic or other psychotropic) and/or provider completing the suggested monitoring for an atypical antipsychotic-related metabolic disorder.

Of note, the pharmacist made an intervention for an average of 1.8 problems per child reviewed, with some children having three or more problems requiring pharmacist intervention.

As evident in Figure 1.1, all interventions achieved a nearly 80% (or higher) intended outcome.

Figure 1.1 Flowchart of Foster Care Review and Psychotropic Drug Oversight Process and Results



This flowchart shows the foster care review, psychotropic drug oversight review, intervention process and outcomes data. Cases from CY 2023 and pending cases from CY 2023 Q4 are included in the chart, as this program is a longitudinal program, meaning we continue to intervene on the same member if there was no response/no change after initial CM intervention. Because some members became ineligible for outcome measurement after an intervention was conducted, the positive response rates listed in the outcomes pane were calculated as members with a positive outcome/members eligible for outcome measurement.

*Provider accepted the suggested medication change.

**Provider completed suggested monitoring or accepted a suggested medication change.

Recommendations

Program Barriers

Our case management program has proven to be successful throughout the years, but we have still identified some barriers we must consider:

- Some members with whom we initiate an intervention (i.e., letter, call) end up in an inpatient facility or residential treatment facility and therefore will skew the results negatively.
- We do not have access to inpatient/institutionalized claims.
- We do not have access to chart notes or laboratory values.
- Some providers who prescribe atypical antipsychotics will not follow lab monitoring guidelines, despite numerous educational interventions. The same providers tend to not respond, which negatively impacts our response rates

This program clearly demonstrates the importance of stable, behind-the-scenes monitoring of our most vulnerable population. Due to the success of this program, we would like to expand our psychotropic monitoring into the pediatric non-foster population.

As noted in Figure 1.1 above, pediatric members within the foster population had multiple reviews per year (665 reviews in 308 children). Therefore, we hope to change our parameters to limit review to one review every six to 12 months to decrease intervention letter fatigue for providers regarding the same issue and potentially improve positive outcome response.

Positive Outreach Examples

Case: 14-year-old male receiving three antipsychotics (quetiapine, lurasidone and haloperidol).

- **Issue:** Member was receiving three antipsychotics, filled monthly and prescribed by the same provider. This triplicate medication therapy can increase the risk for metabolic syndrome, a syndrome that increases the risk for developing obesity, type 2 diabetes, elevated lipids and heart disease. Per diagnoses codes, member was found to have diagnoses of hypertriglyceridemia, hyperlipidemia and obesity.
- **Recommendation:** Consider discontinuing any of the antipsychotic medications to lower risk.
- **Result:** Quetiapine was immediately stopped, and the other two antipsychotics were slowly discontinued. Member is no longer taking an antipsychotic, which greatly decreases the risk for metabolic syndrome.

Case: 12-year-old male receiving three medications that can lower blood pressure and cause sedation (clonidine, prazosin and guanfacine extended-release [ER]).

- **Issue:** Member was receiving two alpha-2 adrenergic agonists (clonidine and guanfacine ER), which are often used for ADHD, but can also lower blood pressure. Member was also receiving prazosin, an alpha-1 blocker, often used for post-traumatic stress disorder (PTSD), which can also lower blood pressure. When taken concomitantly, these medications can lower blood pressure and cause sedation that can impair physical or mental abilities. Additionally, the member did not have a current well-child visit in the database and was also due for metabolic labs for atypical antipsychotic monitoring.
- **Recommendation:** Consider discontinuing any of the antihypertensive medications to lower risk and obtain a well-child visit and metabolic labs.
- **Result:** Guanfacine ER was immediately stopped, and then prazosin was gradually discontinued. Member is now only taking clonidine, which greatly decreases the risk for low blood pressure and sedation. Additionally, the member obtained a well-child visit, which can help ensure vaccinations are up-to-date, track growth and developmental milestones and ensure monitoring for preventive and chronic care. Metabolic labs were also obtained, which can help detect any signs of metabolic syndrome that might occur as a result of taking an antipsychotic.

Case: 13-year-old male receiving more than three psychotropic medications: atypical antipsychotics (risperidone and aripiprazole), high-dose stimulant (dexamethylphenidate) and increasing dose of a selective serotonin reuptake inhibitor (SSRI) (fluoxetine).

- **Issue:** Member was receiving one antipsychotic, filled monthly, and added a second agent (risperidone) prescribed by the same provider. This medication duplication can increase the risk for weight gain, diabetes, dyslipidemia and heart disease, components of metabolic syndrome usually associated with second generation antipsychotics (SGA). Per diagnoses codes, member was found to have a diagnosis of pediatric (<95% for age) and primary obesity. Member was also taking dexamethylphenidate immediate release (IR) 10 milligrams (mg) three times per day (TID) (TDD 30 mg), which is above FDA-approved max dosing for children 6 years and older. Although within dosing range, fluoxetine was also increased to 40 mg daily.
- **Recommendation:** Obtain metabolic labs and continue monitoring for metabolic syndrome, discontinue one of the atypical antipsychotics and implement a dose reduction on immediate release stimulant.
- **Result:** Labs were obtained and recent initiation on metformin (no decrease in stimulant).

Case: 11-year-old female receiving more than three psychotropic medications: two atypical antipsychotics (risperidone and aripiprazole), fluoxetine, methylphenidate ER, propranolol, clonidine and high-dose hydroxyzine.

- **Issue:** Member was receiving two antipsychotics (risperidone 2 mg and aripiprazole 30 mg), filled monthly, and increased from 30 mg to 40 mg on SSRI, prescribed by the same provider. Being on medication of this combination reflects a therapeutic duplication that can increase the risk for weight gain, diabetes, dyslipidemia and heart disease, which are components of metabolic syndrome usually associated with second generation antipsychotics (SGA). Member was also taking methylphenidate ER 27 mg, clonidine IR 0.3 mg, propranolol 30 mg and high-dose hydroxyzine (200 mg TDD). Although some labs were being monitored, no lipid panel was discovered.
- **Recommendation:** Obtain lipid panel labs, continue monitoring for metabolic syndrome, discontinue one of the atypical antipsychotics and implement dose reduction or discontinuation of hydroxyzine.
- **Result:** Lipid labs were obtained, and discontinuation of hydroxyzine was implemented.

Case: 12-year-old male receiving more than three psychotropic medications: two atypical antipsychotics (lurasidone and paliperidone), guanfacine ER, methylphenidate ER and cyproheptadine.

- **Issue:** Member was receiving two antipsychotics (lurasidone 20 mg and paliperidone ER 6 mg), filled monthly, but prescribed by differing providers – paliperidone from pediatrician and lurasidone from psychiatric provider. Being on medication of this combination reflects a therapeutic duplication that can increase the risk for weight gain, diabetes, dyslipidemia and heart disease, components of metabolic syndrome usually associated with SGA. Duplication also can increase the risk of toxicity, adverse events and side effects (movement disorders, sedation, falls, etc.) Member is also taking methylphenidate ER 54 mg, guanfacine ER 4 mg and cyproheptadine 4mg. Although some labs were being monitored, the duplication poses an increased risk.
- **Recommendation:** Continue monitoring for metabolic syndrome, discontinue one of the atypical antipsychotics and perform a well-child exam.
- **Result:** Labs were obtained, well-child exam performed and discontinuation of paliperidone was implemented thereby reducing toxicity risk and reduction in metabolic syndrome risk.

References

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Medical Necessity Criteria – TGH

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

- a. The prognosis for treatment of the serious emotional disturbance of the youth at a less restrictive level of care is poor because the youth demonstrate three or more of the following due to the serious emotional disturbance:
 - i. Significantly impaired interpersonal or social functioning.
 - ii. Significantly impaired educational or occupational functioning.
 - iii. Impairment of judgment.
 - iv. Poor impulse control; or
 - v. Lack of family or other community or social networks.
- b. As a result of the serious emotional disturbance, the youth exhibit an inability to perform daily living activities in a developmentally appropriate manner.
- c. 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.
- d. 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.
- e. 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 to be successfully treated in a less restrictive setting.

Prior Authorization Requirements

The Utilization Review (UR) 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.

- a. 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 to 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.
- b. If the youth become Medicaid eligible while at the TGH; the provider must submit a prior authorization request to the Utilization Review contractor, immediately upon learning the youth is Medicaid eligible.
- c. The clinical reviewer will complete the review process within two business days of receipt of complete information and take one of the following actions:
 - i. 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.
 - ii. Authorize up to 120 days as medically necessary and generate notification to all appropriate parties if the request meets the medical necessity criteria.
 - iii. Defer the case to a board-certified psychiatrist for review and determination if medical necessity criteria are not met.
- d. The board-certified psychiatrist will complete the review and determination within four business days of receipt of the information from the clinical reviewer.
- e. After a denial, a new prior authorization request may be submitted only if there is new clinical information.
- f. For youth being readmitted into TGH services within 14 calendar days of a discharge from TGH services, see continued stay criteria.

For youth in emergency situations who meet the medical necessity criteria for TGH level of care:

A TGH provider may request payment authorization of services for up to 72 hours, pending a prior authorization determination:

- a. The provider must state the nature of the emergency; and
- b. For youth discharging from an acute setting, the physician must certify that the youth is safe to discharge to a TGH.

TGH Service Requirements

TGH services must be provided in accordance with all applicable state and federal regulations and meet the following requirements. A provider must:

- a. Document in the file of the youth how the youth meet the medical necessity criteria within one business day of admission.
- b. Complete and maintain a clinical assessment in accordance with [ARM 37.97.905](#). The prior authorization request does not serve to meet the requirement of the clinical assessment. The clinical assessment must meet the requirements as described in [ARM 37.97.102\(4\)](#).
- c. Meet the therapeutic service requirements as described in [ARM 37.97.906](#);
- d. Meet the treatment plan requirements as described in [ARM 37.97.907](#);
- e. Document attempts to engage the legal representative in treatment planning and progress toward an appropriate discharge placement; and
- f. Complete the discharge task in the Utilization management portal within ten business days of the discharge of a youth from the TGH.

TGH Continued Stay Criteria

Continued stay requests will be considered only when the youth continue to meet the SED criteria and all the following:

- The prognosis for treatment of the serious emotional disturbance at a less restrictive level of care remains poor because the youth still demonstrate two or more of the following:
- Significantly impaired interpersonal or social functioning.
- Significantly impaired educational or occupational functioning.
- Impairment of judgment; or
- Poor impulse control.

As a result of the serious emotional disturbance, the youth exhibit an inability to perform daily living activities in a developmentally appropriate way without the structure of the TGH.

- a. 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.
- b. The youth has demonstrated progress toward identified treatment goals and has a reasonable likelihood of continued progress.
- c. 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.

TGH Continued Stay Review

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.

- a. 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.
- b. The following information must be submitted to the Utilization Review contractor for each continued stay review:
 - i. Changes to current DSM diagnosis.
 - ii. Justification for continued services at this level of care.
 - iii. Description of behavioral management interventions and critical incidents.

- iv. Assessment of treatment progress related to admitting symptoms and identified treatment goals.
 - v. List of current medications and rationale for medication changes, if applicable; and
 - vi. Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan.
- c. 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:
 - i. 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.
 - ii. 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.
 - iii. Defer the case to a board-certified psychiatrist for review and determination if the continued stay does not meet the medical necessity criteria.
 - d. The board-certified psychiatrist will complete the review and determination within four business days of receipt of the information from the clinical reviewer.
 - e. After a denial, a new continued stay request may be submitted only if there is new clinical information.

TGH Benefit Exclusion Criteria

Anyone of the following criteria is sufficient for exclusion from this level of care:

- a. The youth exhibit suicidal or acute mood symptom(s)/thought disorder(s) which require a more intensive level of care.
- b. The youth have medical conditions or impairments that would prevent beneficial utilization of services.
- c. 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.
- d. The admission is being used as an alternative to placement within the juvenile justice or child protective system or as an alternative to
- e. specialized schooling or as respite or as housing.
- f. The youth can be safely and effectively treated at a least intensive level of care.

Operational Eligibility Criteria for DD Services in Montana

1. The person has an Intelligence Quotient (IQ) score of 70 or below. If a person is diagnosed with an intellectual disability based on an IQ greater than 70, the psychologist should provide a specific rationale as to why the person is being considered intellectually disabled (e.g., based on the 95% confidence interval related to 2 standard errors of measurement for a particular test).
2. The person has an Adaptive Behavior Composite score of 70 or less. Here again, the psychologist should provide a specific rationale as to why the person is considered intellectually disabled if the composite score for the adaptive behavior measure is greater than 70.
3. The effect of the person's intellectual disability needs to result in functional limitations in three or more of the following areas of a major life activity:
 - a. Self-care
 - b. Receptive and expressive language
 - c. Learning
 - d. Mobility
 - e. Self-direction
 - f. Capacity for independent living
 - g. Economic self-sufficiency
4. There must be documentation that the developmental disability originated before the person turned age 18.
5. There must be a statement that the developmental disability has continued or can be expected to continue indefinitely.
6. The person must need treatment required by intellectually disabled persons. In accordance with the federal definition of a developmental disability, this treatment reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.
7. For persons from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided, medical records and documentation from the child's physician will be used to make the eligibility determination.

Determining Eligibility in Relation to Autism

To determine developmental disability eligibility in relation to autism spectrum disorder, a person must be determined to meet letter A or letter B, and letter C as described below:

- A. Level 2 guidelines (requiring substantial support) for both social communication and restricted, repetitive behaviors.
- B. Level 3 guidelines (requiring very substantial support) for both social communication and restricted, repetitive behaviors.
- C. Significant impairment of intellectual functioning that is like an intellectual disability and requires similar treatment. Level 2 and Level 3 descriptors are clearly delineated on page 52 of the DSM-5 manual.

Determining Eligibility in Relation to Cerebral Palsy

To determine developmental disability eligibility in relation to cerebral palsy, a person must be determined to demonstrate significant impairment of intellectual functioning that is like an intellectual disability and requires similar treatment.

Determining Eligibility in Relation to Epilepsy

Most persons with epilepsy do not have a developmental disability. To determine developmental disability in relation to epilepsy, a person will typically have uncontrolled seizures and be determined to demonstrate significant impairment of intellectual functioning that is like an intellectual disability and requires similar treatment.

Determining Eligibility in Relation to Other Neurological Conditions

To determine developmental disability eligibility in relation to a person with another neurological condition, the person must be determined in accordance with this Manual to have such a condition and to exhibit significant impairment of intellectual functioning that is like an intellectual disability and requires similar treatment.

Determining Eligibility Where There Is an Apparent Combination of Developmental Disabilities and Mental Illness

A person with an apparent combination of developmental disabilities and mental illness diagnoses may be determined to be eligible for developmental disability services if either number 1 or 2 below are satisfied:

1. The validity section of the person's psychological evaluation report definitively states that the obtained test results were not significantly impacted by behaviors associated with the person's mental disorder (e.g., inattention, lack of motivation, disruptive behaviors, etc.).
2. If a person with a mental disorder in an appeals process is referred for an independent psychological evaluation, then the psychologist should be specifically asked whether the mental illness affected the intelligence test scores or not, and to what extent.
3. Substantial Disability - A "substantial disability" as stated in the Montana Code Annotated (MCA) 53-20- 202(3) is defined as meeting the requirements for I-A, I-B, and I-C under the guidelines for an intellectual disability noted above.
4. Defining Treatment Needs - Treatment like that required by intellectually disabled persons.

Policies and Procedures

The DPHHS BHDD, CMHB, and DDPB are responsible for determining children's Medicaid eligibility for placement in youth TGH, PRTF and Youth DD Group Homes. CFSD does not make the determination to place a child in a DD Group Home. That process is reviewed by DDPB to ensure the placement is appropriate and the waiver services are designed to meet the individual's needs.

CMHB's clinical guidelines require a youth to have a SED and functional impairment to be eligible for placement in a TGH. Children who do not meet these criteria cannot access Medicaid for treatment costs. Below is information on how SED is defined. This definition is taken from CMHB's Medicaid Services provider Manual, May 12, 2023. The list of SED ICD-10 diagnoses is posted outside of the manual under the provider category on the CMHB website.

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 Forms & Applications under the provider Heading 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. A licensed mental health professional must certify the youth continues to meet the criteria for having a serious emotional disturbance annually. The child must exhibit one of the conditions on the list of SED diagnoses. A list of the current specific ICD-10 diagnosis codes is posted on the CMHB website. In addition, the clinical assessment must document how the youth meets the criteria for having a serious emotional disturbance and include specific functional impairment criteria. Both TGH and PRTF services have specific prior authorization and continued stay requirements. PRTF stays require a Certificate of Need (CON).

Serious Emotional Disturbance (SED)

1. To qualify with a 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, except for 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, because 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.

Requirements for a stay at a PRTF

Certificate of Need (CON)

A CON is required. 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

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 decide 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.

- a. If the youth become 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.
- b. Upon receipt of the above documentation, the Utilization Review contractor will complete the following review process:
 - i. 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 decide regarding medical necessity.
 - ii. 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.
 - iii. The clinical reviewer will complete the authorization review within two business days from receipt of additional information.
 - iv. 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.
 - v. The clinical reviewer will defer the case to a board-certified psychiatrist for review and determination if medical necessity criteria are not met.

For a youth to be admitted into an out of state PRTF:

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.

- a. The Montana PRTFs may deny services for one of the following reasons:
 - i. The facility cannot meet the clinical and/or treatment needs of the youth; or
 - ii. An opening is not available.

- iii. 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.
 - A. Legal representatives of all Montana Medicaid youth who are admitted to Out-of-State 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 PRTF must provide services in accordance with all applicable state and federal regulations and meet the following requirements:

- a. A physician must:
 - i. Complete an evaluation of the youth within 24 hours of admission; and
 - ii. Provide weekly treatment to the youth to make treatment adjustments to stabilize the psychiatric disorder of the youth.
- b. 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.
- c. 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.
- d. 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.
- e. 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 Individuals with Disabilities Education Act 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.
- f. PRTF services must meet the educational goals of the youth. The PRTF must:
 - g. Follow as closely as possible an already existing IEP until the IEP is revised or a new IEP is developed; or
 - h. Develop an education plan for a youth without an IEP appropriate to the needs of the youth.
 - i. 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

The youth continue to meet all Medical Necessity Criteria and all the following:

- a. The medical record documents progress toward identified treatment goals and the reasonable likelihood of continued progress.
- b. The youth and family, if appropriate, are demonstrating documented progress toward identified treatment goals and are cooperating with the treatment plan; and
- 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.

The 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.

- a. The following information must be submitted for a continued stay review:
 - i. Changes to current DSM diagnosis.
 - ii. Justification for continued services at this level of care.
 - iii. Description of behavioral management interventions and critical incidents.

- iv. Assessment of treatment progress related to admitting symptoms and identified treatment goals.
 - v. List of current medications and rationale for medication changes, if applicable; and
 - vi. Projected discharge date and clinically appropriate discharge plan, citing evidence toward completion of that plan.
- b. Upon receipt of the above information, the clinical reviewer will complete the continued stay review process:
- vii. 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 decide regarding medical necessity.
 - viii. 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.
 - ix. The continued stay review will be completed within two business days from receipt of additional information.
 - x. The clinical reviewer will authorize the continued stay and generate notification to all appropriate parties if the continued stay meets the medical necessity criteria.
 - xi. The clinical reviewer will defer the case to a board-certified psychiatrist for review and determination if the continued stay does not meet the medical necessity criteria.
- c. 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

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.

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

- Certificate of Need (PRTF/PRTF-AS)

Out-of-State

- Certificate of Need (PRTF/PRTF-AS)
- Interstate Compact Agreement