Children's Mental Health Bureau
Medicaid Services
Provider Manual

July 1st, 2018

Table of Contents

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.

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. 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. A provider should verify the Medicaid eligibility of the youth. Medicaid eligibility can be verified at: Montana Access to Health Web Portal.

Definitions

For the purpose of 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(2).
(3) "Claimant" means as defined in ARM 37.5.304(5).
(4) "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.
(5) "Medical Assistance Provider" means as defined in ARM 37.5.304(12).
(6))"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.
(7) "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.
(8) "Youth" means as defined in ARM 37.87.102(8).

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 page 10.**

(1) All providers should 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) Outpatient therapy;
(h) Community Based Psychiatric Rehabilitation and Support Services; and
(i) 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 document 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;

(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 10 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 any be provided up to 180 consecutive days
Partial Hospital Program (PHP)	Acute Hospital PRTF PRTF-AS CSCT Day TX OP CBPRS ENA	CBPRS may not be provided during PHP program hours
Psychiatric Residential Treatment Facility (PRTF)	Acute Hospital PHP PRTF-AS TGH HSS TFC TFOC-P CSCT Day TX OP CBPRS ENA TCM	TCM may be provided to youth in out of state PRTFs up to 80 units to assist with discharge planning.
Psychiatric Residential Treatment Facility Assessment Service (PRTF-AS)	Acute Hospital PHP PRTF TGH HSS TFC TFOC-P CSCT Day TX OP CBPRS ENA	None
Therapeutic Group Home (TGH)	Acute Hospital PRTF PRTF-AS HSS TFC TFOC-P OP CBPRS	See Coordination of OP with TGH and CSCT section for exceptions and coordination requirements.

Service	May not be provided Concurrently	Notes/Exceptions
Home Support Services (HSS)	Acute Hospital PRTF PRTF-AS TGH TFC TFOC-P ENA	None
Therapeutic Foster Care (TFC)	Acute Hospital PRTF PRTF-AS TGH HSS TFOC-P ENA	None
Therapeutic Foster Care-Permanency (TFOC-P)	Acute Hospital PRTF PRTF-AS TGH HSS TFCP ENA	None
Comprehensive School and Community Treatment (CSCT)	Acute Hospital PHP PRTF PRTF-AS Day TX CBPRS OP ENA	CBPRS may not be provided during the regular school hours of the youth when the youth in enrolled in CSCT. See Coordination of OP with TGH and CSCT section for exceptions and coordination.
Day Treatment (Day TX)	Acute Hospital PHP PRTF PRTF-AS CSCT CBPRS ENA	CBPRS may not be provided during Day TX program hours. ENA may not be provided during Day TX program hours.
Outpatient Therapy (OP)	Acute Hospital PHP PRTF PRTF-AS TGH CSCT ENA	See Coordination of OP with TGH and CSCT section for exceptions and coordination requirements.

Service	May not be provided Concurrently	Notes/Exceptions
Targeted Case Management (TCM)	Acute Hospital PRTF PRTF-AS	TCM may be provided up to 180 consecutive days. Up to 80 units of TCM may be provided to youth in out-of-state PRTFs to assist with discharge planning.
Therapeutic Home Visit (THV)	Acute Hospital PHP PRTF-AS HSS TFC TFOC-P CSCT Day TX OP CBPRS ENA	None
Community Based Psychiatric Rehabilitation and Support Services (CBPRS)	Acute Hospital PHP PRTF PRTF-AS TGH CSCT DAY TX ENA	CBPPRS may not be provided during PHP program hours. CBPRS may not be provided during TGH program hours. CBPRS may not be provided during regular school hours of the youth when the youth in enrolled in CSCT. CBPRS may not be provided during Day TX program hours.
Extraordinary Needs Aide (ENA)	Acute Hospital PHP PRTF PRTF-AS HSS TFC TFOC-P CSCT Day TX OP CBPRS	ENA may only be provided to a youth who is physically at the TFH or on a TGH community outing and receiving TGH services.

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* form from the previous provider.

Upon the discharge of the youth from services which require the provider to notify the department or the Utilization Review Contractor, the provider must complete a *Discharge Notification* form and submit the form. The provider may refer to the appropriate form at CMHB Forms for detailed information pertaining to how and where to submit the form. The timeframes in which to submit the form vary by service and are listed in the services specific section below.

Service	Submit to:	Within:
Psychiatric Residential Treatment Facility (PRTF) and PRTF-AS	Utilization Review Contractor	1 business day
Therapeutic Group Home	Department	5 business days
Home Support Services	Department	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.

Discharge after a denial

(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.

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 for the department or the Utilization Review Contractor and failure to discharge may result in non-payment to providers. Providers and parent/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 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:
(a) 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.
(b) 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.
(c) If a youth is determined to be Medicaid eligible after admission, the youth must also meet clinical management guidelines for Montana Medicaid reimbursement.
(d) 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 UR 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 Provider Forms, land 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 clinical assessment must document how the youth meets the criteria for having a serious emotional disturbance, including specific *functional impairment criteria.

Serious Emotional Disturbance (SED)

(1) To qualify with a Serious emotional disturbance (SED), youth age six and older must:
(a) have been determined by a licensed mental health professional as having at least one of the mental disorders in the table below as a primary diagnosis with a severity specifier of moderate to severe when applied to the current condition of the youth; and
(b) meet the *functional impairment criteria requirements listed in this section.
(2) 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.
(4)) A youth who continues to meet the SED criteria who is receiving children's mental health services, with the exception of PRTF services, may continue to receive services up to age 20 if the youth demonstrates:
(a) a continued need for the services; and
(b) attendance at an *accredited secondary school.

ICD- 10 Diagnostic Codes

Category	DIAGNOSIS	ICD-10
Schizophrenia Spectrum	Schizophrenia	F20.9
	Paranoid schizophrenia	F20.0
	Disorganized schizophrenia	F20.1
	Catatonic schizophrenia	F20.2
	Undifferentiated schizophrenia	F20.3
	Residual schizophrenia	F20.5
	Schizophreniform disorder	F20.81
	Schizoaffective disorder, bi-polar type	F25.0
	Schizoaffective disorder, depressive type	F25.1
	Other Schizoaffective disorders	F25.8

Category	DIAGNOSIS	ICD-10
Bipolar and Related Disorders	Bipolar I disorder, current episode manic w/out psychotic features, moderate	F31.12
	Bipolar I disorder, current episode manic w/out psychotic features, severe	F31.13
	Bipolar I disorder, current episode manic, severe with psychotic features	F31.2
	Bipolar I disorder, current episode depressed, moderate	F31.32
	Bipolar I disorder, current episode depressed, severe, w/out psychotic features	F31.4
	Bipolar I disorder, current episode depressed, severe, with psychotic features	F31.5
	Bipolar I disorder, current episode mixed, moderate	F31.62
	Bipolar I disorder, current episode mixed, severe, w/out psychotic features	F31.63
	Bipolar I disorder, current episode mixed, severe, with psychotic features	F31.64
	Bipolar I disorder in partial remission, most recent episode manic	F31.73
	Bipolar I disorder, in partial remission, most recent episode depressed	F31.75
	Bipolar I disorder, in partial remission, most recent episode mixed	F31.77
	Bipolar II disorder	F31.81
	Other bipolar disorder	F31.89
	Cyclothymic Disorder	F34.0
Category	**DIAGNOSIS**	**ICD-10**
Depressive Disorders	Major depressive disorder, single episode, moderate	F32.1
	Major depressive disorder, single episode, severe w/out psychotic features	F32.2
	Major depressive disorder, single episode, severe with psychotic features	F32.3
	Major depressive disorder, single episode, in partial remission	F32.4
	Major depressive disorder, recurrent, moderate	F33.1
	Major depressive disorder, recurrent, severe w/out psychotic symptoms	F33.2
	Major depressive disorder, recurrent, severe, with psychotic symptoms	F33.3
	Major depressive disorder, recurrent, in partial remission	F33.41
	Persistent depressive disorder (dysthymia)	F34.1
	Disruptive mood dysregulation disorder	F34.8
Category	**DIAGNOSIS**	**ICD-10**
Anxiety Disorders	Panic Disorder	F41.0
	Generalized anxiety disorder	F41.1
	Separation anxiety disorder	F93.0

Category	DIAGNOSIS	ICD-10
Obsessive-Compulsive and Related Disorders	Obsessive-compulsive disorder	F42
Category	**DIAGNOSIS**	**ICD-10**
Trauma and Stressor Related Disorders	Posttraumatic stress disorder	F43.10
	Posttraumatic stress disorder, acute	F43.11
	Posttraumatic stress disorder, chronic	F43.12
	Reactive attachment disorder	F94.1
	Disinhibited social engagement disorder	F94.2
Category	**DIAGNOSIS**	**ICD-10**
Dissociative Disorder	Dissociative identity disorder	F44.81
Category	**DIAGNOSIS**	**ICD-10**
Feeding and Eating Disorders	Anorexia nervosa, restricting type	F50.01
	Bulimia nervosa	F50.2
	Avoidant/Restrictive food intake disorder	F50.8
Category	**DIAGNOSIS**	**ICD-10**
Gender Dysphoria	Gender dysphoria in adolescents and adults	F64.1
	Gender dysphoria in children	F64.2
	Other specified gender dysphoria	F64.8
Category	**DIAGNOSIS**	**ICD-10**
Neurodevelopmental Disorder	Autism spectrum disorder	F84.0
	Attention Deficit/Hyperactivity Disorder, predominantly inattentive presentation, when accompanied by another SED diagnosis	F90.0
	Attention Deficit/Hyperactivity Disorder, predominantly hyperactive/impulsive presentation, when accompanied by another SED diagnosis	F90.1
	Attention Deficit/Hyperactivity Disorder, combined presentation, when accompanied by another SED diagnosis	F90.2
Category	**DIAGNOSIS**	**ICD-10**
Disruptive, Impulse-Control, and Conduct Disorders	Oppositional defiant disorder	F91.3
	Intermittent Explosive Disorder	F63.81

Serious Emotional Disturbance (SED) *Functional Impairment

(1) As a result of the diagnosis of the youth as determined above and for a period of at least six months, or for a predictable period over six months. The youth must also consistently and persistently demonstrate behavioral abnormalities in two or more spheres, to a significant degree, well outside normative developmental expectations. The behavioral abnormalities must have either been in existence for six months or must be reasonably predicted to last six months. They cannot be attributed to intellectual, sensory, or health factors. To qualify a youth must have displayed two or more of the following:

(a) failure to establish or maintain developmentally and culturally appropriate relationships with adult care givers or authority figures;
(b) failure to demonstrate 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 recreation 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) Serious emotional disturbance (SED) means with respect to a youth under six years of age means the youth exhibits a severe behavioral abnormality 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 obviously predictable to continue for a period of 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 results in a risk of personal safety of the child; or
(f) inappropriate and extreme fearfulness or other distress which does not respond to comfort by care givers.

Services

Acute Inpatient Hospital Services	Administrative Rules of Montana ARM Title 37, chapter 86, subchapter 29

Definition Means 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 a current DSM diagnosis that is covered under the provisions of the Montana Medicaid Program, as the primary diagnosis, and at least one of the following:
(a) Dangerous to self or others with continued acuity of risk that cannot be appropriately treated in a less restrictive level of care.

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

Certificate of Need (CON)	A CON is not required. 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.
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).
Required Forms	N/A
Additional Information	

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), or 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.

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	Prior authorization is required. (1) The provider must submit to the Utilization Review Contractor a Prior Authorization Request form 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. (2) If the youth becomes Medicaid eligible while at the facility, the provider must submit a prior authorization and a CON to the Utilization Review Contractor immediately upon learning the youth is Medicaid eligible.

	(3) Upon receipt of the above documentation, the Utilization Review Contractor will complete the following review process: (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. (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. (c) The clinical reviewer will complete the authorization review within two business days from receipt of additional information. (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. (e) 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:** (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. (2) The Montana PRTFs may deny services for one of the following reasons: (a) the facility cannot meet the clinical and/or treatment needs of the youth; or (b) an opening is not available. (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. (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: Interstate Compact on the Placement of Children (ICPC)
Service Requirements	The Psychiatric Residential Treatment Facility must provide services in accordance with all applicable state and federal regulations and meet the following requirements: (1) A physician must: (a) complete an evaluation of the youth within 24 hours of admission; and (b) provide weekly treatment to the youth in order to make treatment adjustments to stabilize the psychiatric disorder of the youth. (2) All legal representatives of 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. (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. (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. (5) If the youth is a student with disabilities, an 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 designed to meet the educational needs of the youth. (6) PRTF services must meet the educational goals of the youth. The PRTF must: (a) follow as closely as possible an already existing Individualized Educational Plan (IEP) until the IEP is revised or a new IEP is developed; OR (b) develop an educational plan for a youth without an IEP appropriate to the needs of the youth. (7) 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. 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: (a) The medical record documents progress toward identified treatment goals and the reasonable likelihood of continued progress as; (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 (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 contact the Utilization Review Contractor no more than ten business days before and no less than five business days prior to the termination of the current certification. (1) The following information must be submitted for a continued stay review: (a) changes to current DSM diagnosis; (b) justification for continued services at this level of care; (c) description of behavioral management interventions and critical incidents; (d) assessment of treatment progress related to admitting symptoms and identified treatment goals; (e) list of current medications and rationale for medication changes, if applicable; and (f) projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan. (2) Upon receipt of the above information, the clinical reviewer will complete the continued stay review process: (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. (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. (c) The continued stay review will be completed within *two business days* from receipt of additional information. (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. (e) The clinical reviewer defers the case to a board certified psychiatrist for review and determination if the continued stay does not meet the medical necessity criteria. For PRTF services, the *Continued Stay Request* form, when completed in its entirety by a physician, physician 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. (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** Certificate of Need (PRTF/PRTF-AS) Prior Authorization Request Form (PRTF) Continued Stay Authorization Request Form (PRTF) Authorization Request Form (Therapeutic Home Visit) Discharge Notification Form, must be submitted to the Utilization Review Contractor within 1 business day of discharge. **Out of State** Interstate Compact Agreement Certificate of Need (Acute Inpatient Hospital/PRTF/PRTF-AS) Prior Authorization Request Form (PRTF) Continued Stay Authorization Request Form (PRTF) Discharge Notification Form, must be submitted to the Utilization Review Contractor within 1 business day of discharge.
Additional Information	**For youth with SED and Developmental Disability:** (1) The PRTF must submit a request for an eligibility determination to the department's Developmental Disability Program (DDP) for youth suspected of having a developmental disability for youth 8 to 18 years of age if a request has not already been made. An eligibility determination for adult services may be requested for youth 16 years or older. (a) the PRTF must complete and submit to the DDP a cover letter along with the psychological testing and assessments required by the DDP; and (b) the PRTF must complete and submit additional documentation, if requested by the DDP. **Corrections to Information** To correct any information provided to the Utilization Review Contractor, the provider must fax the correction on the Corrections to Youth Information form to the department or the Utilization Review Contractor.

Psychiatric Residential Treatment Facility Assessment Service (PRTF-AS)	Administrative Rules of Montana Title 37, chapter 87, subchapter 12

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

- 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.
- 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.
- 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 all of the following: (a) 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. (b) 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. (c) The youth: (i) has had multiple acute psychiatric hospital or PRTF admissions; (ii) is at-risk of being placed in an out-of-state PRTF with an unclear psychiatric presentation; or (iii) is difficult to place due to an unclear or conflicting psychiatric presentation.	
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 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.
Prior Authorization	Prior authorization is required. (1) The provider must submit a prior authorization (PA) to the Utilization Review Contractor no later than two business days prior to admission. (2) The provider must submit a PA to the Utilization Review Contractor for a youth who is being transferred from inpatient psychiatric hospital services to PRTF services no later than two business days prior to the transfer. (3)) A completed CON must accompany the PA request. (4) If the youth becomes Medicaid eligible while at the facility, the provider must submit a PA and a CON to the Utilization Review Contractor immediately upon learning the youth is Medicaid eligible. (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: (1) The youth must be evaluated by a physician within 24 hours of admission; (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. (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. (4) If the youth is a student with disabilities, an 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 designed to meet the educational needs of the youth. (5) PRTF services must meet the educational goals of the youth. The PRTF must: (a) follow as closely as possible an already existing Individualized Educational Plan (IEP) until the IEP is revised or a new IEP is developed; OR (b) develop an educational plan for a youth without an IEP appropriate to the needs of the youth. (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.
Continued Stay Review	A Continued Stay review is not applicable due to the 14-day limitation of this service.
Required Forms	Certificate of Need (Acute inpatient Hospital/PRTF/PRTF-AS) Prior Authorization Request (PRTF/PRTF Assessment) Discharge Notification Form, must be submitted to the Utilization Review Contractor within 1 business day of discharge.
Additional Information	Not applicable.

Partial Hospital Services (PHP)	Administrative Rules of Montana Title 37, chapter 86, subchapter 30

Definition

Is 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 is described at ARM 37.86 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.

Admission Criteria - PHP	
Youth must meet the SED criteria as described in this manual and: (a) 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. (b) 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. (c) 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. (d) The youth can be safely and effectively managed in a partial hospital setting without significant risk of harm to self/others. (e) The services can reasonably be expected to improve the clinical condition of the youth or prevent further regression.	
Certificate of Need (CON)	A CON is not required.

Prior Authorization	Prior authorization is required. (1) The provider must submit to the Utilization Review Contractor a Prior Authorization Request form no later than two business days prior to admission which includes an adequate clinical information must be sufficient for the clinical reviewer to make a determination regarding medical necessity. (2) If the youth becomes Medicaid eligible while at the facility, the provider must submit a prior authorization to the Utilization Review Contractor immediately upon learning the youth is Medicaid eligible. (3) Upon receipt of the above documentation, the Utilization Review Contractor will complete the following review process: (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. (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. (c) The clinical reviewer will complete the authorization review within two business days from receipt of additional information. (d) The clinical reviewer will authorize the admission and generate notification to all relevant parties if medical necessity criteria are met and at least two business days prior to admission. (e) The clinical reviewer will defer the case to a board certified psychiatrist for review and determination if medical necessity criteria are not met. (4) The department may issue the PA for as many days as deemed medically necessary up to 30 days.
Service Requirements	Partial Hospitalization Services must be provided in accordance with all applicable state and federal regulations and meet the following requirements: (1) The provider must: (a) complete a clinical assessment within 10 business days of admission; (b) provide a face-to-face evaluation completed by a physician; (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; (d) initiate active discharge planning at the time of admission to the program and culminate into a comprehensive discharge plan; (e) develop and implement a comprehensive treatment plan that is updated every 30 days or earlier as needed, to reflect progress of the youth; (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; (g) provide crisis intervention and management, including response outside of the program setting; and (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: (a) lower levels of care are inadequate to meet the needs of the youth; (b) 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; (c) demonstrated and documented progress is being made toward the treatment goals and there is a reasonable likelihood of continued progress including a reduced probability of future need for a higher level of care; and (d) demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The treatment team provides a clinical rationale for any recommended changes in the discharge plan or anticipated discharge date.
Continued Stay Review	(1) The provider facility must contact the Utilization Review Contractor no more than ten business days before and no less than five business days prior to the termination of the current certification. (2) The department may issue the continue say for as many days as deemed medically necessary up to 15 days.
Required Forms	Prior Authorization Request Form Certificate of Need Continued Stay Request Form Discharge Plan Review Form (Optional)
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 s/he can be successful in a home setting and to encourage personal growth and development.

Therapeutic Group Home Services include:

- Individual, Group and Family Therapy
- Behavioral and life skills training

Medical Necessity Criteria - TGH

Youth must meet the SED criteria as described in this manual and all of the following:

(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 demonstrates 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 exhibits 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 in order to be successfully treated in a less restrictive setting.

Certificate of Need (CON)	A CON is not required.
Prior Authorization	(1) Prior authorization (PA) is required. (2) The department may issue the PA 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. (3) The department must receive the request for a PA ***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 department.

	(4) The clinical reviewer will complete the PA review process ***within two business days*** of receipt of complete information and take one of the following actions: (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. (b) Authorize the PA for up to 120 days as medically necessary and generate notification to all appropriate parties if the request meets the medical necessity criteria. (c) Defer the case to a board certified psychiatrist for review and determination if the PA request does not appear meet the medical necessity criteria. (5) The board certified psychiatrist will complete the review and determination ***within four business days*** of receipt of the information from the clinical reviewer. (6) After a denial, a new PA request may be submitted only if there is new clinical information. (7) 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 PA determination: (a) the provider must state the nature of the emergency situation; and (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: (1) A provider must: (a) document in the file of the youth how the youth meets 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 form 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); and (c) meet the therapeutic service requirements as described in ARM 37.97.906. (d) document attempts to engage the legal representative in treatment planning and progress toward an appropriate discharge placement. (e) submit a discharge notification form within ten business days of the discharge of a youth from the TGH which can be found at CMHB Forms

Continued Stay Criteria	Continued stay requests will be considered only when the youth continues to meet the SED criteria and all of the following: (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: (a) significantly impaired interpersonal or social functioning; (b) significantly impaired educational or occupational functioning; (c) impairment of judgment; or (d) poor impulse control. (2) As a result of the serious emotional disturbance, the youth exhibits an inability to perform daily living activities in a developmentally appropriate without the structure of the TGH. (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. (4) The youth has demonstrated progress toward identified treatment goals and has a reasonable likelihood of continued progress. (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 2 business days prior to the readmission of the youth.
Continued Stay Review	(1) The department 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. (2) The department must receive the request for continued stay ***no earlier than 10 business days prior to the end*** of the current authorized time period. Requests received earlier than 10 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 department. The department will not retroactively authorize days if a continued stay request is received late. (3) The following information must be submitted to the department for each continued stay review: (a) changes to current DSM diagnosis; (b) justification for continued services at this level of care; (c) description of behavioral management interventions and critical incidents; (d) assessment of treatment progress related to admitting symptoms and identified treatment goals; (e) list of current medications and rationale for medication changes, if applicable; and (f) projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan. (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: (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. (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. (c) Defer the case to a board certified psychiatrist for review and determination if the continued stay does not meet the medical necessity criteria. (5) The board certified psychiatrist will complete the review and determination ***within four business days*** of receipt of the information from the clinical reviewer. (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. (a) The youth exhibits suicidal or acute mood symptom(s)/thought disorder(s) which require a more intensive level of care. (b) The youth has 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 specialized schooling or as respite or as housing. (e) The youth can be safely and effectively treated at a less intensive level of care.
Required Forms	Prior Authorization Request Form (TGH) TGH Continued Stay Request Form Discharge Notification Form, must be submitted to the department within 5 business day of discharge. Discharge Plan Review Form (Optional) Transfer Form
Additional Information	For a youth that is transferring to a different TGH within the same provider the provider must complete and submit a TGH Transfer Form, located at: CMHB Forms.

Home Support Services (HSS)	Administrative Rules of Montana Title 37, chapter 87, subchapter 14

Definition Home Support Services are in-home family support services for youth. They are not available for youth in Therapeutic Foster Care placement. To receive this service, symptoms of the serious emotional disturbance of the youth must be of a persistent nature requiring in-home behavioral intervention. Services are focused on the reduction of behaviors that interfere with the youth's ability to function in the family and community 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. The provider is available by phone or in-person to assist the youth and family during crises. Home Support Services include:

- Functional assessment of the youth and family system
- Crisis planning and response
- Behavioral coaching and training for the youth
- Behavioral coaching and training for the family

Medical Necessity Criteria - HSS

Youth must meet the SED criteria as described in this manual and all of the following:

(a) Symptoms of the serious emotional disturbance of the youth are of a persistent nature requiring intensive in-home behavioral intervention. The specific behavioral intervention need must be documented in the file of the youth as described in Rule 37.87.1407(4)(a) through (d).

(b) The youth exhibits behaviors related to the covered diagnosis that result in risk for placement in a more restrictive environment if in-home services are not provided, or the youth is currently being treated and maintained in a more restrictive environment and requires structured in-home services in order to be successfully discharged to the home.

In addition to the medical necessity criteria the following admission criteria must be met:

(1) The parent/caregiver has agreed to in-home support services to strengthen their capacity to support the youth effectively and improve the functioning of the youth. This should be evidenced by a signature from the youth, if appropriate, and caregiver on the Individualized Treatment Plan (ITP); and

(2) The youth must meet one of the following:

(a) has received services from a Psychiatric Residential Facility (PRTF), acute inpatient, partial hospitalization, therapeutic foster care, or therapeutic group home within the last 45 days; or

(b) if age 3 or under, has been referred by Head Start, day care, or physician as needing services and has been referred or receives Montana's Part C Infant and Toddler Early Intervention Program (Part C) of the Individuals with Disabilities Education Act (IDEA) services and Part C services cannot meet identified needs. Provider must document Part C services cannot meet identified need prior to service provision; or

(c) Outpatient services alone are not sufficient to meet the parent/caregiver's needs for coaching, support, and education. The file of the youth should state clearly what has been tried and the response must include documentation of receiving 3 out of the 4 of the following services:

(i) Outpatient therapy (at least 6 sessions over the past 60 days) OR it has been documented that Outpatient therapy is not available in the home community;

(ii) Targeted Case Management (TCM), as defined on page 43 of this manual, in the last 60 days ;

(iii) Physician or midlevel care or consultation (specific to mental health) in the last 60 days; or

(iv) Documentation that the youth has required crisis intervention more than once in the past 45 days. Documentation must include the date, location, and nature of the crisis situation including an assessment of dangerousness/lethality, medical concerns, and social supports, and the result of the intervention.

Certificate of Need (CON)	A CON is not required.

Prior Authorization	Prior authorization is not required for up to 365 billed days of treatment effective November 15, 2013. Any claim filed in excess of the 365 days without prior approval of the department is eligible for recoupment. Claims are paid in the order received up to 365 days and are not dependent on the dates of the service.
Service Requirement	After the initial 180 days of HSS the provider must document in the file of the youth all of the following: (a) Reassessment of the youth demonstrates the youth continues to meet (a) and (b) of the Medical Necessity criteria. (b) The parent/caregiver continues to need support to improve his/her capacity to parent in order to address the emotional or behavioral needs of the youth as identified in the Individualized Treatment Plan (ITP). (c) 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. (d) The youth and/or parent/caregiver 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 within the year. (e) If the youth and/or parent/caregiver 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. (f) 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	(1) After 365 days of service, the department 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. (2) CMHB clinical staff will review each request for an extension; (3) The legal representative must agree to continue in home support evidenced by their signature on the HSS Service Authorization Request form. (4) The youth must continue to meet the SED criteria for HSS and meet at least two of the following: (a) the youth has documented change in clinical presentation including clinical needs in the last 90 days; (b) the youth has not received HSS services within the past five years (c) the youth required crisis intervention more than once in the last 45 days which is documented. Documentation must reflect: (i) the date of the call; (ii) the staff involved; (iii) the nature of the emergency, including an assessment of dangerousness/lethality, medical concerns, and social supports; and (iv) result of the intervention. (d) the youth has received services in an out of home placement related to the SED diagnosis of the youth in the last 45 day; (e) the youth required greater than the minimum face to face contacts by the HSS Specialist in order to address the mental health needs of the youth and is documented in the file of the youth; or (g) parent or caregiver presents with exceptional clinical need which is documented in the file of the youth.

Continued Stay Review	(1) The department must receive the request for the continued stay ***no earlier than 10 business days*** to the end of the 365 billed treatment days. Requests received earlier than 10 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 department. The department cannot retroactively authorize days if a continued stay request is received late. (2) The following information must be submitted for a continued stay authorization: (a) changes to current SED diagnosis; (b) justification for continued services at this level of care; (c) description of behavioral management interventions and critical incidents; (d) assessment of treatment progress related to admitting symptoms and identified treatment goals; (e) list of current medications and rationale for medication changes, if applicable; and (f) projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan. (3) 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: (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. (d) Authorize the request and generate notification to all appropriate parties if the request meets the medical necessity criteria. (c) Defer the case to a board certified psychiatrist for review and determination if the continued stay does not appear to meet the medical necessity criteria. (5) The board certified psychiatrist will complete the review and determination ***within four business days*** of receipt of the information from the clinical reviewer.
Benefit Exclusion Criteria	(1) Any one of the following criteria is sufficient for exclusion from this level of care. (a)The home environment in which the service takes place presents a serious safety risk to the staff persons who would provide the service. (b) The youth exhibits suicidal or acute mood symptoms/thought disorder which require a more intensive level of care. (c) The youth has medical conditions or impairments that would prevent beneficial utilization of services. (d) Introduction of this service would be duplicative of services that are already in place. (e) 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. (f) The youth can be safely and effectively treated at a less intensive level of care.
Required Forms	HSS Continued Stay Form Discharge Notification Form, must be submitted to the department within 5 business day of discharge. Discharge Plan Review Form (Optional)
Additional Information	In the event a youth meets the medical necessity criteria and demonstrates needs acute enough to require HSS without meeting the above admission criteria, a provider may submit an Exception to HHS Admission Criteria request for consideration

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 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 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 crises.

Therapeutic Foster Care Services include:

- Functional assessment of the youth and family system
- Crisis planning and response
- Behavioral coaching and training for the youth
- Behavioral coaching and training for the foster and natural family

Admission Criteria - TFC

Youth must meet the SED criteria as described in this manual and all of the following:

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

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

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

(d) The youth is transitioning from an out of home placement to a community setting, 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.

Certificate of Need (CON)	A CON is not required.
Prior Authorization	A prior authorization is not required.
Service Requirement	After the initial 180 days of TFC the provider must document in the file of the youth all of the following: (a) Reassessment of the youth demonstrates the youth continues to meet the SED criteria. (b) The foster parent continues to need support to improve his/her capacity to parent in order to address the emotional or behavioral needs of the youth as identified in the Individualized Treatment Plan (ITP). (c) 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. (d) 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. (e) 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. (f) 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. (a) The youth exhibits suicidal or acute mood symptoms/thought disorder which require a more intensive level of care. (b) The youth has medical conditions or impairments that would prevent beneficial utilization of services. (c) Introduction of this service would be duplicative of services that are already in place. (d) 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. (e) 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:

- Functional assessment of the youth and family system
- Crisis planning and response
- Behavioral coaching and training for the youth
- Behavioral coaching and training for the family

Medical Necessity Criteria - TFOC-P

Youth must meet the SED criteria as described in this manual and all of the following:

(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 mental health services;

(b) 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;

(c) 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:

(i) Significantly impaired interpersonal or social functioning;

(ii) Significantly impaired educational or occupational functioning;

(iii) Impairment of judgment; or

(iv) Poor impulse control;

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

(e) As a result of the emotional disturbance or mental illness, the youth exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

Certificate of Need	A CON is not required.
Prior Authorization	A prior authorization is not required.
Service Requirement	After 180 days of TFOC-P the provider must document in the file of the youth the following: (a) The youth must continue to meet all of the admission criteria. (b) The youth and family are engaged in treatment and making progress toward treatment goals; (c) 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 (d) 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 Reviews	Not applicable.
Benefit Exclusion Criteria	Any one of the following criteria is sufficient for exclusion from this level of care. (a) The youth exhibits suicidal or acute mood symptom(s)/thought disorder(s) which require a more intensive level of care. (b) The youth has medical conditions or impairments that would prevent beneficial utilization of services. (c) Introduction of this service would be duplicative of services that are already in place. (d) 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. (e) 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 ARM 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 a behavioral aide, who are assigned to a specific public school. 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 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:

- Individual, Group and Family Therapy
- Behavioral and life skills training

Admission Criteria - CSCT	
Youth must meet the SED criteria as described in this manual. 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 20 units annually.	
Certificate of Need (CON)	A CON is not required.
Prior Authorization	A prior authorization is not required.
Service Requirements	Each youth enrolled in the program must: (a) have an annual assessment as specified in Chapter 3 of this manual; and (b) have an individualized treatment plan in accordance with ARM 37.106.1916.
Continued Stay Criteria	Not applicable.
Continued Stay Review	Not applicable.
Required Forms	Not applicable.
Additional Information	Not applicable.

Day Treatment (DayTx)	Administrative Rules of Montana ARM 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:

- Individual, family, and group therapy
- Social and life skills training
- Therapeutic recreation services

Medical Necessity Criteria - Day Tx	
Youth must meet the SED criteria as described in this manual.	
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.
Required Forms	Not applicable.
Additional Information	Not applicable.

Outpatient Therapy (OP)	Administrative Rules of Montana Title 37, chapter 88

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).

Admission Criteria - OP

For the first 10 **patient sessions per state fiscal year:**
The youth must have a recognized mental health diagnosis.

Outpatient therapy services that do not count towards the 10 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 psychologists; and
(f) Outpatient therapy services provided as part of the CSCT service.

For sessions in excess of 10 per state fiscal year, youth must meet the SED criteria as described in this manual and all of the following:

(a) A family driven Individualized Treatment Plan (ITP) has been formulated on admission 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.
(b) The youth and family, if applicable, have demonstrated investment in the therapeutic alliance and have agreed to the goals/objectives of the ITP.
(c) Progress toward treatment goals has occurred as evidenced by measurable reduction of symptoms or behaviors that indicate continued responsiveness to treatment.
(d) A discharge plan has been formulated and regularly reviewed and revised. It must identify specific target dates for achieving specific goals, and defines criteria for conclusion of treatment.

Certificate of Need (CON)	A CON is not required.
Prior Authorization	A prior authorization is not required.
Service Requirements	(1) Any service requirements as described in the Administrative Rules of Montana and federal regulations.
Continued Stay Criteria	For sessions in excess of 10 per state fiscal year, the mental health professional must document the youth meets the clinical guidelines.
Continued Stay Review	Not Applicable.
Required Forms	Not applicable.
Additional Information	Not applicable.

Targeted Case Management (TCM)	Administrative Rules of Montana Title 37, chapter 86, subchapter 33; and Title 37, chapter 87, subchapter 8.

Definition "Targeted Case management" means the process of planning and coordinating care and services to meet individual needs of a youth and to assist the youth in obtaining necessary medical, social, nutritional, educational, and other services. Case management provides coordination among agencies and providers in the planning and delivery of services.

Case management includes:

- assessment;
- case plan development;
- monitoring; and
- service coordination.

Medical Necessity Criteria - TCM

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

(1) The parent/caregiver gives consent and agrees to participate in TCM.

(2) Within 14 days of admission, the youth has been identified as needing, in addition to TCM, linkage/referral and/or coordination and monitoring of:

(a) two or more mental health services; or

(b) a mental health service and two or more providers or *systems.

(3) The need for TCM must be documented by a mental health professional.

(4) TCM services cannot be used for activities that are the responsibility of other systems.

Certificate of Need (CON)	A CON is not required.
Prior Authorization	A prior authorization is not required.
Service Requirements	Service requirements are located in the Administrative Rules of Montana referenced 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.
Continued Stay Review	The case management program supervisor must verify in the file of the youth that each youth in services meet the above criteria.
Required Forms	Not applicable.

Additional Information	Federal rule or Montana Medicaid **prohibit** the following activities to be billed as case management. (a) Direct delivery of a medical, educational, social, or other service to which an eligible youth has been referred; (b) Medicaid eligibility determination and redetermination activities which includes outreach, application, and referral activities (c) Transportation services. (d) The writing, recording, or entering of case notes in a case file. (e) Coordination of the investigation of any suspected abuse, neglect and/or exploitation cases; and (f) services provided by a case manager while the youth is in an in-state psychiatric residential treatment facility (PRTF) (up to 80 units of TCM is allowed while a youth is in an out-of-state PRTF per ARM 37.87.1211 – as proposed in MAR 37-715). **The case manager's role during crises.** 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. CFR 42.441.18, subpart (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.

Therapeutic Home Visit (THV)	Administrative Rules of Montana Concurrent with Psychiatric Residential Treatment Facility (PRTF) are defined in ARM Title 37, chapter 87, subchapter 12. Concurrent with Therapeutic Group Home (TGH) are defined in ARM Title 37, chapter 87, subchapter 10.

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).

Admission Criteria - THV

The youth must be receiving services in a Therapeutic Group Home or a Psychiatric Residential Treatment Facility.	
Certificate of Need (CON)	A CON is not required.
Prior Authorization	(1) 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 5 business days*** prior to the schedule THV. Requests received earlier than 10 days prior to the scheduled THV 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 department. The department cannot retroactively authorize days if a THV request is received late. (2) The following information must be submitted for a prior authorization for days that exceed three patient days per visit: (a) demonstrates progress toward identified treatment goals; (b) supports a therapeutic plan to transition the youth to a less restrictive level of care; (c) 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 (d) has a viable discharge plan. (3) The clinical reviewer will complete the review upon receipt of complete information as described above and take one of the following actions: (a) Request additional information as needed to complete the review, the provider must submit the requested information before an authorization can be issued. (d) Authorize the request and generate notification to all appropriate parties if the request meets the criteria. (4) 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 1 business days prior to the end*** of the three patient days or the time specified with subsequent authorizations.
Service Requirements	(a) 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; (b) the provider must document staff contact and youth achievements or regressions during and following the therapeutic home visit.

Continued Stay Criteria	Not applicable.
Continued Stay Review	Not applicable.
Required Forms	Therapeutic Home Visit Over Three Days request.
Additional Information	Not applicable.

Community Based Psychiatric Rehabilitation and Support Services (CBPRS)	Administrative Rules of Montana ARM Title 37, chapter 87, subchapter 7.

Definition "Community-based psychiatric rehabilitation and support (CBPRS)" means additional one-to-one, face-to-face, 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.	
Certificate of Need (CON)	A CON is not required.
Prior Authorization	A prior authorization is not required except when provided concurrently with the 1915(i) Home and Community Based state plan or the PRTF waiver.
Service Requirements	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. CBPRS group services may only be provided: (a) up to a maximum of two hours of group per day; (b) up to a maximum of eight youth per group; and (c) up to a staff ratio of four youth to one staff. Community-based psychiatric rehabilitation and support may include the following services: (a) evaluation and assessment of symptomatic, behavioral, social and environmental barriers; (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; (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 (d) immediate intervention in a crisis situation to refer the youth to necessary and appropriate care and treatment. Community-based psychiatric rehabilitation and support does not include the following: (a) interventions provided during day treatment or partial hospitalization program hours, or if a youth is enrolled in CSCT during school hours; (b) interventions provided in a hospital, therapeutic group home, or residential treatment facility; (c) interventions provided by staff of group homes;

	(d)) case planning activities, including attending meetings, completing paperwork and other documentation requirements, traveling to and from the home of the youth; (e) therapeutic interventions by licensed practitioners; and (f) activities which are purely recreational, instructional, or vocational in nature.
Continued Stay Criteria	Not applicable.
Continued Stay Review	Not applicable.
Required Forms	Not applicable.
Additional Information	Not applicable.

Extraordinary Needs Aide Service (ENA)	Administrative Rules of Montana 37.87.1013

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.

Admission Criteria - ENA

Youth must meet the SED criteria as described in this manual and all of the following:

(a) exhibit extreme behaviors that cannot be managed by the TGH staffing required by licensure ARM 37.97.903.

(b) The extreme behaviors of the youth are current, moderately severe, and consist of documented incidents that are symptoms of the SED of the youth.

(c) The behaviors are either frequent in occurrence, or at risk of becoming a serious occurrence, and include one or more of the following behaviors:

- harming self or others;
- destruction of property; or
- a pattern of frequent extreme physical outbursts.

Certificate of Need (CON)	A CON is not required.
Prior Authorization	(1)) A prior authorization is required. To request prior authorization of ENA services, the Lead Clinical Staff must complete the department's ENA request form and document the medical need for the service. (2) The ENA request must include: (a) a behavior assessment; (b) a detailed description of the behavioral problems of the youth including date(s) of occurrence(s) and frequency of behavior problems to justify the number of ENA hours being requested; and (c) measurable ENA treatment plan goals and objectives. (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: (a) Request additional information as needed to complete the review, the provider must submit the requested information before an authorization can be issued. (b) Authorize the request and generate notification to all appropriate parties if the request meets the medical necessity criteria.
Service Requirement	ENA must provide a one to one staffing ratio. Daily progress notes must include time in and time out. 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	(a) continues to meet admission criteria; (b) demonstrates progress towards identified treatment goals and the reasonable likelihood of continued progress; and (c) 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	(1) If continued authorization is requested, a new ENA request form must be completed prior to the end of the authorization period with: (a) an updated behavior assessment; (b) a description of the behavior problems with new goals and objectives; and (c) dates and frequency of behavior problems. (2) If the information on the ENA request form is incomplete, the service will not be authorized.
Required Forms	Authorization Request form (Extraordinary Needs Aide)
Additional Information	Not applicable.

Genetics Testing for Children's Mental Health	Administrative Rules of Montana 37.12

Definition

Genetic test are 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.

Admission Criteria: Genetic Testing

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

1. Youth displays clinical feature or is at direct risk of inheriting a gene 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.

Certificate of Need (CON)	A CON is not required.

Prior Authorization	(1) A prior authorization is required. (2) To request prior authorization for mental health genetics testing, the lab or physician must complete the department's genetics testing prior authorization request form and document the medical need for the service. (3) The request must include: (a) Documented clinical features indicating risk of inheriting the mutation in question. (b) Documented previous medication failures. (c) Comprehensive history of youth and physical examination. (4) 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: (a) Request additional information as needed to complete the review, the provider must submit the requested information before an authorization can be issued. (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. (c) Deny request and generate notification.
Service Requirement	Genetics testing must follow all relevant Montana Medicaid rules. Prior authorization number must be present on the lab's claim for payment.
Continued Stay Criteria	Not Applicable.
Continued Stay Review	Not Applicable.
Required Forms	Authorization Request form (Mental Health Genetics Testing For Youth)
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 of all provider requested services or services units.

Pending Authorization

A pending authorization indicates the clinical reviewer or psychiatrist has requested additional information from the provider.

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.

Reconsideration Review Process for PRTF Services

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 for the following services:
(a) Psychiatric Residential Treatment Facilities; and
(b) Psychiatric Residential Treatment Facilities - AS.

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 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 located in the determination letter sent by the department or the Utilization Review Contractor. At any time during this review process a new prior authorization request may be submitted to provide additional clinical information and to begin an updated request for determination.
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.

Technical denial – PRTF

If a technical denial is issued for submission of information outside the allowable timeframes, a provider may submit a new prior authorization request to the department or its designee. Requesting a new prior authorization after a technical denial does not waive the right to request an administrative review of the technical denial.

A new prior authorization request may not be back dated and must provide sufficient clinical information to support an authorization. If the new prior authorization request is approved, the provider may request an administrative review of the unauthorized days.

Chapter 5 - The Appeal Process

Administrative Review/Fair Hearing

Claims Denial Administrative Reviews

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) 624-3858 (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 Review/ Fair Hearing Process

Complete information about administrative reviews and fair hearings is found in administrative rule at Title 37, chapter 5.

Chapter 6 - Reviews

Retrospective Reviews/ Quality Audit Reviews

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

(a) to determine necessity of a provided service; or

(b) 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:

(a) there is sufficient evidence of medical necessity for payment;

(b) the youth is receiving active and appropriate treatment consistent with standards of practice for the diagnosis, age and circumstances of the youth; or

(c) 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;

(a) the purpose of the review; and

(c) 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 if after the youth has discharged.

(2) A provider must submit to the department or the Utilization Review Contractor:

(a) documentation that the youth met medical necessity criteria; and

(b) a prior authorization or 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. The administrative rules which govern Medicaid provider sanctions are located 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 the parent/legal representative and/or the provider, via the U.S. Postal Service.

Notification for technical denials will include:
dates of service that are denied payment due to non-compliance with procedure;
(a) references to applicable regulations governing the review process;
(b) an explanation of the right, if any, to request an administrative review/fair hearing; and
address and fax number of CMHB to request an administrative review, if applicable.

Notification for clinical denial determination will include:
(a) the date or dates of service that is 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.

The provider has the right to appeal a claim denial.

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.