CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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The Virginia Medicaid Program covers a variety of psychiatric services for eligible recipients. This chapter describes these services and the requirements for the provision of them. Contents of the chapter are organized under the following main headings:

- Inpatient Psychiatric Services
- Treatment Foster Care - Case Management (TFC-CM)
- Outpatient Psychiatric and Substance Abuse Services

INPATIENT PSYCHIATRIC SERVICES (ACUTE HOSPITAL AND RESIDENTIAL)

Acute Care Hospitals

Psychiatric acute inpatient services are available to recipients of all ages in psychiatric units of general acute care hospitals. For recipients 21 years of age and older, coverage is provided for days that are medically necessary and is limited to a maximum of 21 days. This 21-day limit applies to the first eligible 21 days of hospitalization for the same diagnosis within a 60-day period. The 60-day period begins with the first approved day of a hospital admission. Only 21 total days will be covered for the same or similar diagnoses, whether incurred in one or more hospital stays or in the same or multiple hospitals, during the 60-day period. For recipients receiving treatment who are under the age of 21, inpatient psychiatric services are covered beyond the 21-day limit as long as criteria are met. Refer to the *Hospital* Provider Manual for specific requirements for acute care facilities.

Freestanding Hospitals - Over Age 65 Category

Services for recipients, ages 22 to 64, are not reimbursable by Medicaid in an Institution for Mental Diseases (IMD). "Institution for Mental Diseases" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an IMD.

Certification of Need for Care in Freestanding Hospitals

A physician must certify for each recipient that inpatient services in a freestanding psychiatric hospital are needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a freestanding psychiatric hospital, before the Medicaid agency authorizes payment. Refer to the *Hospital* Provider Manual for specific requirements for acute care facilities.

A physician, physician assistant, or nurse practitioner, acting within the scope of practice and under the supervision of a physician, must recertify for each recipient that inpatient psychiatric services are needed. This recertification must be made at least every 60 days.

Medical, Psychiatric, Social Evaluations, and Admission Review - Freestanding Hospitals

Prior to admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each recipient's need for care in the hospital. In addition, appropriate professional personnel must make a psychiatric and social evaluation. Each medical evaluation must include:

1. Diagnoses;
2. Summary of present medical findings;
3. Medical history;
4. Mental and physical functional capacity;
5. Prognosis; and
6. A recommendation by a physician concerning admission to the freestanding psychiatric hospital or continued care in the hospital for individuals who apply for Medicaid while in the freestanding psychiatric hospital.

Plan of Care - Freestanding Hospitals

Prior to admission to a freestanding psychiatric facility or before authorization for payment, the attending physician or staff physician must establish a written Plan of Care for each recipient. The Plan of Care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the recipient;
3. Objectives;
4. Any orders for: medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient;
5. Plans for continuing care, including review and modification to the Plan of Care; and
6. Plans for discharge.

The attending or staff physician and other personnel involved in the recipient's care must review each Plan of Care at least every 90 days.

Freestanding (Psychiatric) Hospital and Residential Treatment Facility Under Age 21

Medicaid will pay for inpatient psychiatric services in a freestanding hospital and in residential treatment facilities for individuals under age 21, whose need for services has been identified through an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening.

The criteria for Medicaid reimbursement for freestanding inpatient psychiatric services has been established based on the federal regulations in 42 CFR § 441, Subpart D, and §§ 16.1-335 and §§ 37.1-67.1 of the Code of Virginia. Any Medicaid-eligible individual seeking admission to a freestanding psychiatric hospital or residential treatment facility must be certified as requiring inpatient services in order for the psychiatric facility to receive Medicaid reimbursement for the admission.

Independent Team Certification

Federal regulations (42 CFR § 441.152) require certification by an independent team that inpatient psychiatric services are needed for any recipient applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility or residential treatment facility. The certification must be current, within 30 days prior to placement. The independent team must include mental health professionals, including a physician. The independent team will be from the Community Services Board (CSB) serving the area in which the individual resides. Pre-screenings are not reimbursable by Medicaid. For residential treatment for Comprehensive Services Act (CSA) children, the independent team will be the local Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.1-753-755 of the Code of Virginia. The majority of the team (at least 3 members) and the physician must sign the Certificate of Need/DMAS 370 form (see the "Exhibits" section at the end of this chapter for a sample of this form). Team members must have competence in the diagnosis and treatment of mental illness (preferably in child psychiatry) and have knowledge of the individual's situation (42 CFR § 441.153). The justification for certification must be child-specific. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

A Medicaid-reimbursed admission to an acute care facility, a freestanding psychiatric facility, or a residential treatment facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the recipient;
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

The certification of need for hospital admission and for non-CSA residential placements must be documented on the Pre-Admission Screening Report (DMH 224) or similar form, which must be signed and dated by the screener and the physician (see "Exhibits" section at the end of this chapter for a sample of this form). It is not sufficient to merely check on the DMH 224 that each of the above Certification-of-Need criteria has been met. For non-CSA residential placements the DMAS 370 may also be used. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs. For emergency acute care admissions, federal regulation (42CFR 441.153) allows up to 14 days for the team responsible for the Plan of Care in the facility to certify the admission. The certification must meet the

criteria listed above. The team must meet the criteria for the treatment team (42CFR 441.156) listed in this chapter under the Comprehensive Individual Plan of Care section.

An emergency acute care admission is defined as a psychiatric hospitalization that is required, because the individual is a danger to himself or others or when the individual is incapable of developmentally appropriate self-care due to a mental health problem. The admission follows a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

If a child resided in a psychiatric residential facility, requires an acute psychiatric admission, and is returning to a psychiatric residential facility, a new Certificate of Need is required. The certification may be completed by the acute facility physician and treatment team as long as the physician meets the criteria noted in federal regulations 42 CFR 441.152-153.

A physician, physician assistant, or nurse practitioner acting within the scope of practice and under the supervision of a physician must recertify for each recipient that inpatient psychiatric services are needed. This must be done at least every 60 days.

Initial Plan of Care

In accordance with federal requirements (42 CFR § 441.156), the team must establish a written Plan of Care at admission, which must be signed and dated by the attending or staff physician, indicating the physician has examined the child and approved the plan. The plan must include:

- The diagnosis, symptoms, and complaints indicating the need for admission;
- A description of the functional level of the recipient;
- Recipient-specific treatment objectives with short- and long-term goals;
- Orders for medications, treatments, therapies, etc.;
- Plans for continuing care, including review of the Plan of Care;
- Prognosis; and
- Discharge plans.

Any available medical, social, and psychiatric evaluations must be submitted with the Certification of Need to the freestanding inpatient psychiatric hospital. The Certification of Need must be completed and dated prior to admission and the request for authorization.

For residential admission, the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS)[1] must also be completed and current within 90 days throughout the residential stay. For non-CSA children, a CAFAS is not required.

Development of the Comprehensive Individual Plan of Care for Residential Treatment

The Comprehensive Individual Plan of Care (CIPOC) is a written plan developed for each recipient. The CIPOC must be completed no later than 14 days after admission for residential treatment and must include the dated signatures of the team members specified in the federal

[1] These instruments are available from Kay Hodges, Ph.D, 2140 Old Earhart Road, Ann Arbor, MI 48105, (734) 769-9725

requirements (42 CFR 441.156). The CIPOC must be completed before requesting continued stay. The Plan of Care must:

- Be based on diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for inpatient care;
- Be developed by a team of professionals in consultation with the recipient, and the recipient's parents, legal guardians, or others in whose care the recipient will be released after discharge;
- State recipient-specific treatment objectives with measurable short- and long-term goals with target dates for achievement;
- Prescribe an integrated program of therapies, activities, and experiences designed to the meet the stated objectives; and
- Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to achieve the recipient's discharge from inpatient status at the earliest possible time and ensure continuity of care with the recipient's family, school, and community upon discharge.

The diagnostic evaluation upon which the Plan of Care is to be developed may include medical, social, and psychological evaluations that were completed prior to the individual's admission to the psychiatric facility and submitted with the Certification of Need.

The medical and psychological evaluations of the need for inpatient psychiatric care must include:

a. Diagnoses;
b. Summary of present medical findings;
c. Medical/psychiatric history;
d. Mental and physical functional capacity; and
e. Prognosis.

The social evaluation must include the psychosocial assessment and an evaluation of home plans and available community resources.

The provider is expected to aggressively treat individuals with a full range of therapies and educational and recreational activities. For residential treatment, all of the services must be provided at the facility as part of the therapeutic milieu. This includes medication management, psychotherapy, and an appropriate school program. Medicaid reimbursement for inpatient psychiatric services will not be available for inpatient stays during which active treatment, according to the goals and objectives related to the individual's diagnostic needs, is not provided, or the individual no longer requires inpatient treatment due to his or her psychiatric condition. The recipient is allowed a maximum of 18 days annually of therapeutic leave while in residential care. The purpose of the leave days is to facilitate discharge from residential treatment. The therapeutic purpose, goals, and response to the leave must be documented.

It is critical that the Initial Plan of Care and the CIPOC be developed by a team of professionals in consultation with the recipient and the recipient's parents, legal guardians, or others in whose care the recipient will be released after discharge. In accordance with federal requirements

(42 CFR § 441.156), the team must include one of the following:

- A Board-eligible or Board-certified psychiatrist; or
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases; **and**
- a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

The team must also include one of the following:

- A psychiatric social worker; or
- A registered nurse with specialized training, or one year's experience, in treating mentally ill individuals; or
- An occupational therapist who is licensed, if required by the state, and who has specialized training, or one year of experience, in treating mentally ill individuals; or
- A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

For residential treatment, the CIPOC must be reviewed, signed, and dated every 30 days by the team specified above.

ACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICES CRITERIA

A. Definitions

- "Acute" means within 24 hours.
- "Active Treatment" means implementation of a professionally developed and supervised individual Plan of Care.
- "Ambulatory Care" means services provided in the recipient's home community, which may include: outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- "On Admission" means within four hours.
- "Recent Onset" means within one week.
- "Severe Psychiatric Disorder" means clinical manifestation, symptoms, or complications which are so severe as to preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and which require 24-hour nursing/medical assessment, intervention, or monitoring.

B. Severity of Illness

1. Care and treatment shall be provided in the least restrictive treatment environment possible. The following shall be reviewed by DMAS to determine whether or not a lower level of care or ambulatory care was considered and found inappropriate to meet the needs of the recipient.

    a. Recipient is currently receiving ambulatory care and not responding to treatment; or

    b. Recipient's identified condition is escalating; or

    c. Recipient's condition is of an emergency nature with recent onset or is a reoccurrence of a previous acute psychotic condition; or

    d. Recipient's condition requires monitoring of newly prescribed drugs with a high rate of complication or adverse reactions; or

    e. Recipient's condition requires monitoring for toxic effects from therapeutic psychotropic drugs.

2. Individuals admitted for inpatient hospital level of care must be diagnosed with a severe psychiatric disorder. There must be documented evidence of recent onset of one of the following conditions:

    a. Current suicide attempt or ideation. Behavior reflecting a suicide attempt or suicidal intent with a plan. Degree of intent, availability of method, and immediacy of plan should support the decision to admit; or

    b. Current assaultive, self-mutilative, or destructive behavior. Immediate danger to self or others is apparent. This behavior must require intensive psychiatric medical management and nursing interventions on a 24-hour basis; or

    c. Current hallucinations (visual or auditory) or bizarre or delusional behavior. Patient exhibits reality testing deficits or hypomanic behavior severe enough to present danger to self or others; or

    d. Inability to perform activities of daily living (ADLs) because of severe psychiatric symptoms. This may include psychomotor retardation, severe depression, social withdrawal, agitation, autistic or catatonic behavior; or

    e. Disorientation or memory impairment to the degree of endangering welfare; or

    f. Loss of body control, total body rigidity, immobility, seizures (withdrawal or toxic), or obsessive-compulsive behavior, which cannot be controlled.

3. The following disorders do not justify inpatient hospital admission unless the other

severity of illness criteria in B (1) and B (2) above or medical criteria are also met:

a. Organic brain syndrome

b. Hyperactivity

c. Attention deficit disorders

d. Dyslexia

e. Behavior or personality disorders

f. Eating disorders

g. Alcohol and/or drug abuse

h. Mental retardation

i. Alzheimer's disease

4. Some examples of non-reimbursable services include, but are not limited to:

a. Remedial education

b. Evaluation for educational placement or long-term placement

c. Day care

d. Behavioral modification

e. Psychological testing for educational diagnosis, school, or institutional admission or placement

f. Alcohol or drug abuse therapy, without a co-occurring mental illness

g. Residential treatment

h. Partial hospitalization programs

C. Intensity of Treatment Required - To meet criteria for continued stay, the intensity of treatment must relate to the severity of illness with the goal of improving or preventing regression of the recipient's condition so services will no longer be needed.

1. The active treatment plan must relate to the admission diagnosis and reflect:

a. At least one of the following:

(1) Physical restraint/seclusion/isolation; or
(2) Suicidal/homicidal precautions; or
(3) Escape precautions; or
(4) Drug therapy (any route) requiring specific close medical supervision; and

b. All of the following:

(1) A licensed professional (psychiatrist, clinical psychologist, psychiatric clinical nurse specialist, licensed clinical social worker, marriage and family therapist, or licensed professional counselor) provides individual/group or family therapy on at least five out of seven days, in addition to the therapy session, at least one appropriate treatment intervention occurs on the same five out of seven days. No more than one individual therapy session per day is billable, and there is a maximum of ten individuals per group psychotherapy session. On days when there is no individual, group, or family therapy, there must be at least two appropriate treatment interventions.
Treatment interventions may include, but are not limited to psychoeducational groups, socialization groups, behavioral interventions, individual counseling, play/art/music therapy, and occupational therapy. Therapeutic treatment interventions may be facilitated by nurses, social workers, psychologists, mental health workers, occupational therapists, and other appropriately prepared hospital staff; and
(2) The family, caretaker, or case manager is involved on an ongoing basis with treatment planning and family members participates in family therapy at a minimum of once per week unless documentation demonstrates, based on the treatment plan, why it is not feasible and addresses alternative involvement in therapy; and
(3) Active treatment and discharge planning begin at admission.

2. Medical record documentation must include all of the following:

a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis; and

b. Continued necessity for skilled observation, structured intervention, and support that can only be provided at the hospital level of care; and

c. Concurrent documentation of therapeutic interventions (billable psychotherapy and non-billable interventions that meet the weekly requirement) as provided, including individual treatment, according to the treatment plan, specific to hours and number of days provided, topics covered, and response to the therapy; and

d. Dated signatures of qualified providers; and

e. All medical documentation must also include the time the notations are made; and

f. If the minimum treatment outlined in C.1.b.(1) above is not provided, document why the individual was unable to participate.

3. Therapeutic Passes:

a. One therapeutic day pass is allowed if the goals of the day pass are documented prior to the day pass and if, on return, the effect of the day pass is documented. If the first day pass is determined not to have reached the goals and indications exist, a second day pass may be permitted. Day passes, which are not a part of the written plan of treatment or documented as to expected and experienced therapeutic effect, are not permitted.

b. Overnight passes are not permitted.

D. Expected Outcome/Discharge - Continued hospital level-of-care is not appropriate and will not be covered when one or more of the following exist:

1. The stabilization of presenting symptoms with demonstrated ability to perform ADLs appropriate for age and to function appropriately within hospital environment; or

2. The required treatment can be provided in a less restrictive environment; or

3. The type or dosage of major psychotropic medication has been unchanged for the last five days or there is medical documentation to support no variation in drug therapy; or

4. There has been no documented evidence of a change in treatment plan when the recipient has not responded in a seven-day period; or

5. The recipient refuses to cooperate with the treatment plan.

INPATIENT RESIDENTIAL TREATMENT SERVICES CRITERIA

Definitions:

- "Active Treatment" means implementation of a professionally developed and supervised individual Plan of Care.
- "Ambulatory Care" means services provided in the recipient's home community, which may include outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- "On Admission" means within 24 hours.
- "Recent Onset" means within seven days.
- "Residential inpatient care" means a 24-hour-per-day specialized form of highly organized,

intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders. All services must be provided at the facility as part of the therapeutic milieu.

- "Licensed Mental Health Professional" includes a psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric clinical nurse specialist, marriage and family therapist, a licensed professional counselor, or a school psychologist.

Locality Responsibility

Prior to placement, the locality is responsible for checking the Medicaid eligibility file to determine that the correct responsible city or county is designated. The locality noted on the eligibility file (managed by the locality's eligibility office) will be credited on the monthly CSA report provided to the Office of Comprehensive Services for any Medicaid-paid claims for residential placements. The locality should be the same as the one noted on the CSA Reimbursement Rate Certification form (see the "Exhibits" section at the end of this chapter for a sample of this form). If there is any question, the locality should check with their county Department of Social Services (DSS) Eligibility Office.

The admission and documentation criteria are:

A. Severity of Illness (both 1 and 2 must be met):

1. Care and treatment shall be provided in the least restrictive treatment environment possible. The following shall be reviewed by DMAS to determine whether a lower level of care or ambulatory care was considered and found inappropriate to meet the needs of the recipient. *One or more must be present:*

    a. The recipient is currently receiving community-based care with evidence of failure at a less restrictive level of care;
    b. The recipient's identified condition is escalating; or
    c. The recipient's condition is a reoccurrence of a previous acute psychiatric condition.

2. Individuals admitted for inpatient residential level of care must have been diagnosed with a psychiatric disorder. There must be documented evidence of recent onset of *one or more* of the following conditions:

    a. The recipient is unable to function in a less restrictive environment evidenced by dysfunction in interpersonal, family, education, or development;
    b. The recipient has had a history of acute psychiatric episodes and currently is not making progress or cooperating with the treatment plan in a less restrictive level of care;
    c. There are recent increased threats of harm or aggression towards self or others;
    d. The recipient is unable to function safely in the community without jeopardizing the safety of self or others;
    e. There has been recent stabilization of symptoms during a psychiatric

hospitalization but the recipient needs a structured 24-hour therapeutic environment to prevent regression, solidify gains, and/or further resolve complex psychiatric symptoms; or

f. Recent outpatient treatment has failed. Ambulatory care resources available in the community do not meet treatment needs because the individual suffers one or more complicating concurrent medical disorders which the family is not effectively addressing (e.g., conduct disorder with seizures, depression with insulin-dependent diabetes mellitus).

B. Intensity of Treatment Required - To meet criteria for admission, the intensity of treatment must relate to the severity of illness with the goal of improving the recipient's condition so services will no longer be needed, or preventing progression to an acute stage.

1. The active treatment plan must relate to the admission diagnosis and reflect *all of the following*:

a. A licensed professional (psychiatrist, clinical psychologist, licensed clinical social worker, licensed professional counselors, or clinical nurse specialist-psychiatric with education and experience with children and adolescents) provides individual therapy three out of seven days. No more than one session per day is billable; and

b. A minimum of 21 distinct sessions (excluding individual treatment, school attendance, and family therapy) of appropriate treatment interventions are provided each week (i.e., group therapy with specific topics focused to patient needs; insight-oriented and/or behavior modifying). (Group medical psychotherapy coverage is limited to once per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as separately billable group psychotherapy sessions. There is a maximum of ten individuals per group psychotherapy session.). Play/art/music therapy, occupational therapy, and physical therapy may be included; however, these modalities of treatment must not be the major treatment modality; and

c. The family, guardian, caretaker, or case manager is involved on an ongoing basis with treatment planning. The family, guardian, or caretaker participates in family therapy at a minimum of twice monthly except when the family dysfunction is a reason for admission, then family therapy should be at least once per week. At least one of these family therapy sessions must be face-to-face each month. Family therapy is limited to one unit per day, regardless of the number of participants or family members in the session. If the family, guardian, or caretaker is not involved as required, documentation must demonstrate why it is not feasible or not in the best interest of the child for the family to participate. Alternatives for treatment due to the lack of a family's involvement should be addressed (telephonic therapy is a non-reimbursable service) and the discharge plan revised to address the lack of family involvement; and

d. Active treatment and comprehensive discharge planning for aftercare placement and treatment must begin at admission.

2. Medical record documentation must include *all of the following:*

   a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis; and
   b. Continued need for skilled observation, structured intervention, and support that can only be provided at the residential level of care; and
   c. Concurrent documentation of therapeutic interventions (billable psychotherapy and non-billable interventions that meet the 21 intervention-per-week requirement) as provided. Progress notes for each session must describe how the activities of the session relate to the recipient-specific goals, the frequency and duration of the session, the level of participation in treatment, the type of session (group, individual), and the plan for the next session. Notes must contain the dated signatures of the qualified providers. Examples of some types of non-billable sessions include educational, socialization, recreational, current events, nursing, and grooming;
   d. For CSA cases, a current CAFAS or PECFAS (at a minimum, due every 90 days); and -
   e. If the minimum treatment outlined in B.1 above is not provided, document why the individual was unable to participate.

Residential Treatment Continuing Stay Criteria

A. Severity of Illness - *All of the following must be present*:

   1. Continued complex presenting symptoms or emergence of new symptoms that are amenable to treatment in a psychiatric residential facility; and
   2. Recipient involved and cooperative with treatment; and
   3. Continued impairment in level of functioning; and
   4. Continues to require restrictive setting; and
   5. Ambulatory care resources available in the community will not meet the treatment needs; and
   6. Continued services can reasonably be expected to improve the condition or prevent further regression.

B. Intensity of Treatment - *All of the following services must be provided in order to meet Continuing Stay criteria*:

   1. The multidisciplinary recipient-specific treatment plan must be updated every 30 days. It must include recipient-specific long- and short-term goals, measurable objectives, and interventions with time frames for achievement; the treatment plan must be revised to address goals achieved, unresolved problems, and any new problems which have arisen; and
   2. For CSA cases, the CAFAS or PECFAS must be updated by the locality and available in the medical record, at a minimum every 90 days; and
   3. Services must continue to require the supervision of a physician; and
   4. Integrated program of therapies including milieu therapy, activities, and experiences designed to meet the treatment objectives; active provision of

interventions including individual, group, and, if applicable, family therapy as required in B.1 (a-d) above.

Expected Outcome/Discharge Criteria - Continued residential level of care is not appropriate and will not be covered when *one or more of the following exist (severity of illness and intensity of treatment should be reviewed):*

A. The stabilization of presenting symptoms with demonstrated ability to perform ADLs appropriate for age and to function appropriately within residential environment and a community setting;

B. The required treatment can be provided in a less restrictive environment;

C. There is documented evidence, from the use of day and an overnight pass, that the recipient has been able to function safely and satisfactorily within the community;

D. There has been no documented evidence of a change in treatment plan when the recipient has not responded for a 20-day period; or

E. The recipient refuses to cooperate with the treatment plan.

Special Notes

1. The following disorders do not justify residential treatment facility admission unless the other severity-of-illness criteria or medical necessity criteria are also met:

   a. Hyperactivity
   b. Attention deficit disorders
   c. Dyslexia
   d. Behavior or personality disorders
   e. Eating disorders
   f. Alcohol and or drug abuse
   g. Mental retardation

2. Some examples of non-reimbursable services include:

   a. Remedial education
   b. Evaluation for educational placement or long-term placement
   c. Day care
   d. Psychological testing for educational diagnosis, school, or institutional admission and/or placement
   e. Partial hospitalization programs

3. Therapeutic Passes:

   a. Therapeutic passes are permitted if the goals of the pass are part of the master

treatment plan. The goals of a particular visit must be documented prior to granting the pass and, on return, its effects must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to a day pass. The function of the pass is to assess the recipient's ability to function outside the structured environment and to function appropriately within the family and community.

b. Days away from the facility may occur only after the completion and documentation of successful day passes and as a part of the discharge plan. Outcomes of the therapeutic leave must be documented. No more than 18 days of therapeutic leave annually are billable. Days of leave are counted from the date of admission to Medicaid-covered service.

4. If a child requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 7 days this should be addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If a child requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

   None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a DMAS residential authorization.

5. Residential treatment services may not be billed concurrently with any Community Mental Health Rehabilitative Services, with two exceptions: Intensive In-Home Services for Children and Adolescents (H2021) and Case Management (T1017 HE). These two services may be billed for up to seven days, immediately upon admission to a residential facility or immediately prior to discharge from a residential facility, to transition the child from home to the residential setting or from the residential setting to home, as applicable.

TREATMENT FOSTER CARE - CASE MANAGEMENT (TFC-CM)

Children under age 21 in Treatment Foster Care (TFC) who are Seriously Emotionally Disturbed (SED) or children with behavioral disorders, who, in the absence of such programs, would be at risk for placement into more restrictive residential settings, are eligible for Treatment Foster Care - Case Management (TFC-CM).

Treatment Foster Care - Case Management (TFC-CM) means an activity, that assists Medicaid recipients in gaining and coordinating access to necessary care and services appropriate to their needs.

TFC-CM is directed toward children or youth with a behavioral disorder or emotional disturbance referred to Treatment Foster Care by the Family Assessment and Planning Team of the Comprehensive Services Act (CSA) for Youth and Families or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.1-755 of the Code of Virginia. "Child" or "youth" means any Medicaid-eligible child under age 21 years of

age who is otherwise eligible for CSA services. Family Assessment and Planning Teams (FAPTs) are multidisciplinary teams of professionals established by each locality in accordance with § 2.1-754 of the Code of Virginia to assess the needs of children referred to the team. The FAPT shall develop individual service plans for youths and families reviewed by the team. The FAPT shall refer the children needing TFC-CM to a qualified participating case manager.

TFC-CM is a component of treatment foster care through which a case manager provides treatment planning, monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child. Services to the children shall be delivered primarily by treatment foster parents who are trained, supervised, and supported by professional child-placing agency staff. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented. Services shall not include room and board. The following activities are considered covered services related to TFC-CM services:

1. Care planning, monitoring of the plan of care, and discharge planning;

2. Case management; and

3. Evaluation of the effectiveness of the child's plan of treatment.

Duties of a TFC Case Manager are to:

- Perform a periodic assessment to determine the child's needs for psychosocial, nutritional, medical, and educational services;

- Develop individualized treatment plans to describe the services and resources needed to meet the needs of the child and to help access those services and resources;

- Coordinate services and service planning with other agencies and providers involved with the child;

- Refer the child to services and support specified in the individualized treatment and service plans;

- Follow up and monitor ongoing progress in each case to ensure services are delivered by continually evaluating and reviewing each child's Plan of Care;

If a child is temporarily out of the home, documentation of active case management services is required to bill for the time the child is out of the home in the following situations:

1. Placement for inpatient services, in cooperation with the facility, to assist in discharge planning for transition back to the home;

2. Runaway – if the case manager is actively involved in finding the child to be returned to the home; and

3. Detention – refer to the Chapter III discussion on "inmate" and verify Medicaid eligibility.

4. No other type of case management may be billed concurrently with targeted case management.

Caseload Size: The TFC Case Manager shall have a maximum of 12 children in his/her caseload for a full-time professional staff person. The caseload shall be adjusted downward if:

1. The caseworker's job responsibilities exceed those listed in the agency's job description for a caseworker, as determined by the supervisor.

2. The difficulty of the client population served requires more intensive supervision and training of the treatment foster parents.

3. Exception: A caseworker may have a maximum caseload of 15 children as long as no more than 10 of the children are in TFC and the above criteria for adjusting the caseload downward do not apply.

4. There shall be a maximum of six children in the caseload for a beginning trainee that may be increased to nine by the end of the first year and to 12 by the end of the second year.
5. There shall be a maximum of three children in a caseload for a student intern, if any work in the agency.

Treatment Teams in TFC-CM

The TFC-CM provider shall assure that a professional staff person provides leadership to the treatment team, which includes managing team decision-making regarding the care and treatment of the child and services to the child's family. The provider must provide information and training to the treatment team members as necessary. The provider must involve the child and the child's family in treatment team meetings, plans, and decisions and keep them informed of the child's progress whenever possible. Treatment team members shall consult as often as necessary, but no less than quarterly.

Treatment Plans in TFC-CM

The TFC-CM provider shall prepare and implement an individualized comprehensive plan for each child in its care. When available, the parents shall be consulted unless parental rights have been terminated. If parents cannot be consulted, the agency shall document the reason in the child's record.

Comprehensive Treatment Plan in TFC-CM

The case manager and other designated child-placing agency staff shall develop and implement for each child in care an individualized comprehensive treatment plan within the first 45 days of placement that shall include:

1. A comprehensive assessment of the child's emotional, behavioral, educational, and medical needs;

2. The treatment goals and objectives, including the child's specific problems, behaviors, and skills to be addressed, the criteria for achievement, and target dates for each goal and objective;

3. The TFC-CM provider's program of therapies, activities, and services, including the specific methods of program of therapies, activities, and services, the specific methods of intervention and strategies designed to meet the above goals and objectives, and describing how the provider is working with related community resources to provide a continuity of care;

4. The discharge plan and the target date for discharge from the program;

5. For children age 16 and over, a description of the programs and services that will help the child transition from foster care to independent living; and

6. The plan shall be signed and dated by the case manager. It shall indicate all members of the treatment team who participated in its development.

The case manager shall include and work with the child, the custodial agency, the treatment foster parents, and the parents, where appropriate, in the development of the treatment plan, and a copy shall be provided to the custodial agency. A copy shall be provided to the treatment foster parents as long as confidential information about the child's birth family is not revealed. A copy shall be provided to the parents, if appropriate, as long as confidential information about the treatment foster parents is not revealed. If any of these parties do not participate in the development of the treatment and service plan, the case manager shall document the reasons in the child's record.

The case manager shall provide supervision, training, support, and guidance to foster families in implementing the treatment plan for the child.

Progress Reports and Ongoing Services Plans in TFC-CM

The case manager shall complete written progress reports beginning 90 days after the date of the child's placement and every 90 days thereafter. The progress report shall specify the time period covered and include:

1. Progress on the child's specific problems and behaviors and any changes in the methods of intervention and strategies to be implemented, including:

   a. A description of the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement, and target dates for each goal and objective;

   b. A description of the therapies, activities, and services provided during the previous 90 days toward the treatment goals and objectives; and

   c. Any changes needed for the next 90 days.

2. Services provided during the last 90 days toward the discharge goals, including plans for reunification of the child and family or placement with relatives, any changes in these goals, and services to be provided during the next 90 days, including:

    a. The child's assessment of his or her progress and his or her description of services needed, where appropriate;

    b. Contacts between the child and the child's family, where appropriate;

    c. Medical needs, specifying medical treatment provided and still needed and medications provided;

    d. An update to the discharge plans including the projected discharge date; and

    e. A description of the programs and services provided to children 16 and older to help the child transition from foster care to independent living, where appropriate.

Annually, the progress report shall address the above requirements as well as evaluate and update the comprehensive treatment and service plan for the upcoming year. The case manager shall date and sign each progress report.

The case manager shall include each child who has the ability to understand in the preparation of the child's treatment and service plans and progress reports or document the reasons this was not possible. The child's comments shall be recorded in the report. The case manager shall include and work with the child, the treatment foster parents, the custodial agency, and the parents, where appropriate, in the development of the progress report. A copy shall be provided to the placing agency worker and, if appropriate, to the treatment foster parents.

<u>Contacts with the Child in TFC-CM</u>

1. There shall be face-to-face contact between the case manager and the child, based upon the child's treatment and service plan and as often as necessary, to ensure that the child is receiving safe and effective services.

2. Face-to-face contacts shall be no less than twice a month, one of which shall be in the foster home. One of the contacts shall include the child and at least one treatment foster parent and shall assess the relationship between the child and the treatment foster parents.

3. The contacts shall assess the child's progress, and guidance to the treatment foster parents, monitor service delivery, and allow the child to communicate concerns.

4. A description of all contacts shall be documented in the narrative.

5. Children who are able to communicate shall be interviewed privately at least once a month.

6. The case manager shall record all medications prescribed for each child and all reported

side effects or adverse reactions.

Unless specifically prohibited by a court or the custodial agency, foster children shall have access to regular contact with their families as described in the treatment and service plan. The case manager shall work actively to support and enhance child-family relationships and work directly with the child's family toward reunification as specified in the treatment and service plan.

Professional Clinical or Consultative Services in TFC-CM

In consultation with the custodial agency, the case manager shall provide or arrange for a child to receive psychiatric, psychological, and other clinical services as recommended or identified in the treatment service plan.

Record Documentation in TFC-CM

Entries in Case Records: All entries shall include the dated signature of the individual who performed the service. If a TFC-CM provider has offices in more than one location, the record shall identify the office that provided the service. Each child's record shall contain documentation that verifies the services rendered for billing.

Narratives in the Child's Record: Narratives shall be in chronological order and current within 30 days. Narratives shall include areas specified in these regulations and shall cover: treatment and services provided; all contacts related to the child; visitation between the child and the child's family; and other significant events. Each contact with the child, his or her family, foster family, or other individuals in the course of providing case management services must be documented in the child's record.

Plans of Care: Copies of all assessments and Plans of Care must be filed in the child's case record.

Assessment

Each child must be assessed by a Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.1-755 of the Code of Virginia. The team must assess the child's immediate and long-range therapeutic needs, developmental priorities, personal strengths and liabilities, the potential for reunification with the recipient's family, set treatment objectives, and prescribe therapeutic modalities to achieve the plan's objectives. The assessment must include the dated signatures of a majority (at least three) of the FAPT members.

Medical Necessity Criteria

The child must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on a state-designated Uniform Assessment Instrument (UAI). The child's condition must meet one of the three levels described below:

a. **Level I:** Moderate impairment with one or more of the following moderate risk factors as

documented on the CAFAS:

(1) Needs intensive supervision to prevent harmful consequences;
(2) Moderate/frequent disruptive or non-compliant behaviors in home setting that increase the risk to self or others; or
(3) Needs assistance of trained professionals as caregivers.

b. **Level II:** The child must display a significant impairment with problems with authority, impulsivity, and caregiver issues as documented on the CAFAS. For example, the child must:

(1) Be unable to handle the emotional demands of family living;
(2) Need 24-hour immediate response to crisis behaviors; or
(3) have severe disruptive peer and authority interactions that increase risk and impede growth.

c. **Level III:** The child must display a significant impairment with severe risk factors as documented on the CAFAS. The child must demonstrate risk behaviors that create significant risk of harm to self or others.

OUTPATIENT PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

Outpatient psychiatric and substance abuse (SA) services are provided in a practitioner's office, mental health clinic, patient's home, or skilled nursing facility. If services are provided in a setting other than the office or a clinic, this must be documented. Services shall be medically prescribed treatment, which is documented in an active written treatment plan designed, signed, and dated by a Licensed Mental Health Provider (LMHP). A separate plan is required for psychiatric services and SA services when prior authorization is requested separately. The primary diagnosis should indicate the focus of treatment. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed with the expectation the clinician will bill for the primary presenting problem.

Criteria for Participation

In order for a recipient to qualify to receive outpatient psychiatric and substance abuse services, the recipient must meet ALL of the following criteria:

A. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired;

B. Exhibits deficits in peer relations, deficits in dealing with authority, hyperactivity, poor impulse control, clinical depression, or demonstrates other dysfunctional symptoms having an adverse impact on attention and concentration, the ability to learn, or the ability to participate in employment, educational, or social activities;

C. Is at risk for developing or requires treatment for maladaptive coping strategies; and

D. Presents a reduction in individual adaptive and coping mechanism or demonstrates extreme increase in personal distress.

Documentation Required (what must be in the medical record)

- History, to include:
  - The onset of the diagnosis and functional limitations;
  - Family dynamics; ability/desire of the family/caretakers to participate and follow through with treatment;
  - Reasons that may require consideration (foster care, dysfunctional family);
  - Previous treatment and outcomes;
  - Medications, current and history of;
  - Medical history if relative to current treatment;
  - Treatment received through other programs (Department of Rehabilitative Services, day treatment, Special Education, Community Services Board, or the Department of Mental Health, Mental Retardation and Substance Abuse Services clinics.

- Functional limitations.

- Plan(s) of Care, and review of the plan of care signed and dated by the qualified provider.

- Medical Evaluation (evidence of coordination with the PCP, if applicable, or documentation that it is not applicable). The purpose of the evaluation is to rule out any underlying medical condition as causing the symptoms, and to ensure that any underlying medical conditions are being treated.

- Results of a Diagnostic Evaluation done within the past year. The chief complaint should relate to the psychiatric or substance use diagnosis that is current, within the past year.

- For SA services, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

- Progress Notes for each session (must describe how the activities of the session relate to the client-specific goals, the length of the session, the level of participation in treatment, the modalities of treatment, the type of session [group, individual], the progress or lack thereof toward the goals, and the plan for the next treatment and must contain the dated signatures of the providers).

- Evidence of Discharge Planning.

- Discharge Criteria for Substance Abuse Services:

ADULTS
After completion of 12 months of treatment, the patient should be discharged from active treatment if the following criteria are met:

- No active cravings for illegal substances that impact Activities of Daily Living (ADLs)
- No current preoccupations with getting high or past drugging experiences that impact ADLs
- Minimal or manageable guilt, remorse, and/or shame
- No drug seeking behaviors
- No drug glorification that impact ADLs
- Has attended 80% or more of the scheduled individual/group/family therapy sessions in the past mont
- Has no uncontrolled abusive or addictive behaviors at home, at work or in peer interactions
- Has had no positive drug screens or positive breathalyzer tests in the last 6 months
- Has family/peer connections that support sobriety.

At this point the person is eligible to enter into a relapse prevention phase of treatment for an additional 6 months, to include:

- One session of individual or group therapy every 2 weeks
- Random urine or breathalyzer monitoring at least twice in 6 months
- Encourage: attendance at 12-step programs

ADOLESCENTS
After completion of 12 months of treatment, the patient should be discharged from active treatment if the following criteria are met:

- No active cravings for illegal substances that impact Activities of Daily Living (ADLs)
- No current preoccupations with getting high or past drugging experiences that impact ADLs
- Minimal or manageable guilt, remorse, and/or shame
- No drug seeking behaviors
- No reckless or acting out behaviors directly related to substance use/abuse
- Has attended 80% or more of the scheduled individual/group/family therapy sessions in the past month
- Has no uncontrolled abusive or addictive behaviors at school or in social life
- Has had no positive drug screens or positive breathalyzer tests in the last 6 months
- Has family/peer connections that support sobriety

At this point the person is eligible to enter into a relapse prevention phase of treatment for an additional 6 months, to include:

- One session of individual or group therapy every 2 weeks
- Random urine or breathalyzer monitoring at least twice in 6 months
- Encourage: attendance at 12-step programs

- Discharge Summary (including the reason for the discharge and any follow-up needed).

Plan of Care (elements of the initial and ongoing plan of care)

- *Focus of the Plan* must be related to the diagnosis.
  Must have a DSM-IV-TR psychiatric or SA diagnosis including current mental status documented in the medical progress notes.

- Must indicate client-specific goals related to symptoms and behaviors.

- Must indicate treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual; all modalities will be considered with appropriate documentation).

- Must indicate estimated length that treatment will be needed.

- Must indicate frequency of the treatments/duration of the treatment.

- Must indicate documentation of the family/caregiver participation.

- Qualified provider must sign and date the plan of care.

- The Plan of Care must be reviewed by the provider every 90 days or every sixth session, whichever time frame is shorter, from the date of the provider's signature.

  - Has there been a relapse?

  - Has there been a significant change in the environment?

  - Is the individual at risk for moving to a higher level of care?

  - Positive/negative changes relative to the symptoms.

  - Documented review of the plan of care by a qualified therapist/personnel (the provider)

Specific Service Limits

- The individual, family, and group psychotherapy and substance abuse services are

limited to no more than three visits in a seven-day period when performed as an outpatient service.

- The substance abuse treatment sessions are separate from the psychiatric services. When medically necessary, there may be concurrent authorizations for substance abuse treatment and psychiatric services. For persons with co-occurring psychiatric and substance abuse conditions, providers are encouraged to integrate the treatment. The most appropriate service, either psychiatric or substance abuse treatment would be prior authorized. If the service limit of three sessions in a seven-day period will be exceeded, another level of service may be more appropriate, such as Intensive Outpatient Services or Substance Abuse Day Treatment. Criteria for both services are described in the Medicaid Community Mental Health Rehabilitative Services manual available on the DMAS website.

- Individual therapy coverage is limited to once per day.

- Interpretation of examinations, procedures and data, and the preparation of reports are non-covered services. This includes CPT code 90885 (psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes). Review of records or reports are included in the interview examination. A psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medial interpretation of laboratory, or other medical diagnostic studies.

- Group therapy coverage is limited to once per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy sessions. There is a maximum of ten individuals per group session.

- Family therapy is limited to once per day.

- Multiple-family group therapy is a non-covered service.

- Medical hypnotherapy; environmental intervention; interpretation of examinations, procedures, and data; and the preparation of reports remain non-covered services.

- Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation prior to admission to a nursing facility, or any placement issue. Medical records must document the medical necessity for these tests. DMAS allows one per six-month period and up to seven hours of units. Should the testing exceed the limits of frequency or units, the provider must provide the documentation with the bill as to the medical necessity for the testing and a list of the specific tests conducted.

- Separate payment will be allowed for the attending physician and the anesthesiologist involved in electroconvulsive therapy.

- 90805, 90807, 90809, 90811, 90813, and 90815 are codes that include medical evaluation

and management and only psychiatrists, psychiatric nurse practitioners and psychiatric clinical nurse specialists may bill these codes when appropriate. If these codes are used, evaluation and management cannot also be billed separately.

- 90804 through 90815, 90846, 90847, 90853 and 90857 are codes designated for Substance Abuse services, with the HF modifier.
- Substance Abuse Treatment Practitioners are only eligible to provide CPT codes with HF modifiers, excluding the evaluation and management codes.

Non-Covered Psychiatric Services

The following services are non-covered services:

- Broken appointments;
- Remedial education;
- Day care;
- Psychological testing done for purposes of educational diagnosis or school admission or placement;
- Occupational therapy;
- Teaching "grooming" skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered;
- Telephone consultations;
- Mail order prescriptions;
- Psycho-education for the purpose of educating the recipient's guardian about the diagnosis and any related symptoms/treatment; and
- Teaching parenting skills.

EXHIBITS

TABLE OF CONTENTS

UNIFORM PREADMISSION SCREENING FORM

This form is to be completed by a qualified professional designated by the Community Services Board to determine if an individual meets criteria for civil commitment or is in need of voluntary or involuntary admission to a psychiatric hospital. Please refer to the Uniform Preadmission Evaluation Procedures and the Continuity of Care Guidelines.

DATE _____ **TIME (From** _____ **To**_____**)** **DISPOSITION: VOL TDO OTHER CASE NO.**_____

I. PERSONAL DATA

Name: _____ Age: _____ Date of Birth: _____

Address: _____
(Street) (City or County) (State) (Zip Code)

Phone: ( )_____ Marital Status: _____ SSN: _____

Physical description: _____ _____ _____ _____ _____ _____
(Sex) (Race) (Height) (Weight) (Hair Color) (Eye Color)

Emergency Contact: _____ Relationship to Client: _____

Address: _____
(Street) (City or County) (State) (Zip Code)

Phone: Home ( )_____ Work ( )_____

Monthly Income: $_____ SSI/SSDI: $_____ Payee: _____ Veteran: Y N ?

Insurance: Y N ? _____ _____
(Name of Insurance Company) (Group/Plan Number)

Medicaid: Y N ? #_____ Medicare: Y N ? #_____

(If under 18) School Division: _____ School Attending: _____ Grade: _____ Special Education: Y N

CSB of Origin: _____ Contacted: Y N N/A **PRAIS Code**

Name of CSB Staff Contacted:_____ Phone ( )_____

II. LEGAL DATA

Pending legal charges: Y N - If yes, complete the following information: Nature of charges (if known): _____

Date of hearing (if known): _____ Court of Jurisdiction: _____ Client serving a sentence: Y N ?
NGRI Conditional Release: Y N ? Probation/Parole: Y N ? Contact:_____

III. COLLATERAL SOURCES OF INFORMATION		Yes	No	N/A
Client Record	(Agency)			
Individual Requesting Evaluation	(Name & Relationship to Patient)			
Primary Therapist	(Name)			
Other	(Name & Relationship to Patient)			

IV. FOR LOCAL USE

2

V. MEDICAL

Primary Care Provider: _____ Phone ( )_____

Medical History & Current Medical Problems/Symptoms:_____

_____

_____

Medication: Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

	Name	**Dose**	**Schedule**	**Length of Time Taken**
1.				
2.				
3.				
4.				
5.				

Recent medication changes: Y N ? (If yes, explain) _____

Allergies or adverse side effects to medications: Y N ? (If yes, explain)_____

_____

Has client complied with recommended medication and treatment plans? Y N ? (If no, describe nature of non-compliance)_____

_____

VI. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT: Service providers (e.g., Eastern State Hospital, CSB, CSB contractual agency, private provider, etc.) and services and/or treatment provided.

	Service Provider/Facility	**Services/Treatment Provided**	**Date Last Seen**
1.			
2.			
3.			
4.			

VII. PRESENT SITUATION (Include information such as precipitating events, stressors and variation, if any, from baseline level of functioning. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3

VIII. MENTAL STATUS EXAM (Circle all that apply)

Appearance:	WNL	unkempt	poor hygiene		bizarre	tense	rigid	
Behavior/Motor Disturbance:	WNL	agitation	guarded	tremor	manic	impulse control	psychomotor retardation	
Orientation:	WNL	disoriented:	time	place	person	situation		
Speech:	WNL	pressured	slowed	soft/loud	impoverished	slurred	other	
Mood:	WNL	depressed	angry/hostile	euphoric	anxious	anhedonic	withdrawn	
Range of Affect:	WNL	constricted	flat	labile	inappropriate			
Thought Content:	WNL	delusions	grandiose	ideas of reference	paranoid	obsessions	phobias	
Thought Process:	WNL	loose associations	flight of ideas	circumstantial	blocking	tangential	perseverative	
Perception/ Sensorium:	WNL	hallucinations:	auditory	visual	olfactory	tactile	illusions	
Memory:	WNL	impaired:	recent	remote	immediate			
Appetite:	WNL	poor	Weight: loss	gain	Appetite: increased	decreased		
Sleep:	WNL	hypersomnia	onset problem	maintenance problem				
Insight:	WNL	blaming	little	none				

Estimated Intellectual/Functional Capacity: above average | average | below average | diagnosed MR

Explain clinically significant findings: _____

_____

_____

_____

_____

_____

_____

IX. SUBSTANCE ABUSE ASSESSMENT (Check if no current use _____)

	Hx	Past 24 hrs	Blood Present	Drug of Choice	Frequent (Past 30 days)	Method	Last used
Tremors			N/A	**Primary:**			
Seizures			N/A	**Secondary:**			
DT's			N/A	**Comments/Test Results:**			
Vomiting			Y N				
Diarrhea			Y N				

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X. RISK ASSESSMENT

Suicide Potential: Hx of ___Attempts Current __Attempt __Ideation ___Intent Plan: ____Vague Plan: ____Defined ____Means Active ____Psychosis Current ___Substance Abuse

Homicide Potential: Hx of ___Assault Assault or __ Attempt __ Ideation ___Intent Plan: ___ Vague Plan: ____Defined ____Means Active ___ Psychosis Current ___Substance Abuse

Specify: _____

_____

_____

XI. DIAGNOSIS: DSM IV (P=Provisional, H=Historical) **GAF:** _____

Axis I: _____

Axis II: _____

XII. FINDINGS (Circle)

X **Is / is not** mentally ill and/or abusing substances.
X **Is / is not** an imminent danger to self or others.
X **Is / is not** able to care for self.
X **Is / is not** capable of consenting to voluntary treatment/hospitalization.
X **Is / is not** willing to be treated voluntarily.
X There **are / are not** less restrictive community alternatives to serve this person.

_____

XIII. DISPOSITION RECOMMENDATION (Check appropriate "PreDetention" box if evaluation is conducted prior to the issuance of a T.D.O. Check appropriate "PreHearing" box if evaluation is conducted after the issuance of a T.D.O. but prior to the commitment hearing.)		
PreDetention		**PreHearing**
	Client does not meet criteria for hospitalization and/or commitment and should be encouraged to participate in community based services.	
Not Applicable	Involuntary commitment to outpatient services because client meets criteria for involuntary commitment, community alternatives are available for involuntary commitment, and client is incapable or unwilling to consent to voluntary treatment.	
	Voluntary hospitalization because client does not meet criteria for involuntary commitment, has the capacity to consent to voluntary treatment, requires treatment in a hospital and has requested said treatment.	
Not Applicable	Voluntary hospitalization because the client requires treatment in a hospital, has the capacity to consent to treatment, and if, in the presence of the special justice and under court order, the client agrees to a voluntary period of treatment up to 72 hours and to give 48 hours notice to leave in lieu of involuntary commitment for up to 180 days.	
	Involuntary hospitalization because client meets criteria for involuntary hospitalization and is incapable of consenting to voluntary treatment.	
	Involuntary hospitalization because client meets criteria for involuntary hospitalization, is capable of consenting to voluntary treatment, but is unwilling to be treated voluntarily.	

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XIV. FINDINGS OF HEARING EVALUATOR (*To be completed if "PreHearing" Disposition Recommendation differs from "PreDetention" Disposition Recommendation.*):

XV. TREATMENT AND DISCHARGE PLANNING (*to be completed only if inpatient treatment is recommended).*

Individuals who can assist in treatment and discharge planning (i.e., family, discharge planner, therapist, family physician, etc.)

Name	**Phone No.**	**Relationship to Client**
1.		
2.		
3.		

Inpatient treatment goals: _____

Services to be considered in planning for discharge:

____medication management	____substance abuse services	____housing /residential services
____case management	____financial support/entitlement	____medical/dental/nutritional services
____outpatient (ind., fam., group)	____adult or child protective services	____legal assistance/advocacy
____psychosocial/day treatment	____transportation	____nursing home care

____other_____

_____ _____

Signature of Prescreener | Prescreening Agency/Board

_____ _____

Print Name Here | Date

_____

Signature of Hearing Evaluator

_____ _____

Print Name Here | Date

SAMPLE FORM

CERTIFICATION OF NEED FOR ADMISSION
TO
RESIDENTIAL PSYCHIATRIC TREATMENT

Child's Name_____

Under each of the three sections below, a child-specific explanation must be provided.

1. Ambulatory/outpatient care does not meet the specific treatment needs of the recipient:
_____
_____
_____
_____
_____
_____

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
_____
_____
_____
_____
_____

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
_____
_____
_____
_____
_____

For children who are Medicaid recipients, this form must be completed and signed by the local CSA interdisciplinary team or FAPT and signed by a physician member of the team. The physician cannot be the treating physician at the facility to which the child will be admitted. If the child is in acute care, the acute care physician may complete the CON.

Team Signatures: _____Date_____ _____Date_____

_____Date_____ _____Date_____

_____Date_____ _____Date_____

Physician Signature: _____ Date: _____

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CSA Reimbursement Rate Certification
Residential Treatment

Name of Child: _____

Medicaid Number: _____

Residential Treatment Provider:

_____

Address: _____
Street

_____,_____,_____
City State ZIP

Provider Number: _____

Community Policy and Management Team:

County/City _____

Address: _____
Street

_____
City State ZIP

I certify that the following rate, $_____ per day, has been negotiated for the above-named child for Medicaid reimbursable Residential Treatment
The Medicaid rate noted above should reflect the negotiated rate minus expected reimbursement from all other payment sources, such as Title IV-E. The total reimbursement from all other sources cannot exceed the Medicaid maximum rate for this service. This rate shall be effective for dates of service beginning on _____/____/_____

MONTH DAY YEAR*

CPMT Signature: _____

Print Name: _____

Title: _____

Date: _____

*Date must be current year.

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Example form for DMAS purposes only. *This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.*

INITIAL PLAN OF CARE

Name:

Medicaid Number:

Admission Date:

DSM-IV
- **Axis I**
- **Axis II**
- **Axis III**
- **Axis IV**
- **Axis V**

Describe Symptoms, Complaints, and Complications Indicating the Need for Admission to Residential Level of Care (Include problem behaviors 7 days prior to admission)**:**

Functional Level (Medical issues, ability to do activities of daily living)**:**

3 Long-Term Goals with Measurable Treatment Objectives/Interventions:

1. **1.**
2. **2.**
3. **3.**

3 Short-Term Goals with Measurable Treatment Objectives/Interventions:

1. **1.**
2. **2.**
3. **3.**

Orders for Medications (note name, dosage and frequency):

Orders for Therapies (type, frequency, duration)

Individual Therapy:

Family Therapy:

Other Therapies (describe):

Other Orders:

Plans for Continuing Care and for Review of the Plan of Care:

Discharge Plan (including estimated date of discharge):

Physician's Dated Signature (Name, title, handwritten date):

Example form for DMAS purposes only. *This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.*

COMPREHENSIVE INDIVIDUAL PLAN OF CARE

Resident Name:

Medicaid Number:

Admission Date:

DSM-IV:
- **Axis I**
- **Axis II**
- **Axis III**
- **Axis IV**
- **Axis V**

Describe the Need for Residential Level of Care (symptoms and behaviors):

3 measurable long-term goals with target dates for achievement and each with measurable treatment objectives/interventions:

1. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

2. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3 measurable short-term goals with target dates for achievement and each with measurable treatment objectives/interventions (should relate to long-term goals):

1. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

2. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

Orders for Medications (note name, dosage and frequency):

Orders for Therapies (note type, frequency, duration):

Individual Therapy:

Family Therapy:

List the 21 planned therapeutic interventions:

Other Therapies (i.e. Group Psychotherapy, Occupational, Physical Therapy):

Other Orders:

Summary of Progress and Justification for Continued Stay (if there is no progress, describe how treatment is being adjusted to address the lack of progress):

Discharge Plan (including estimated date of discharge):

Physician's Dated Signature

SIGNATURE	TITLE	DATE

TEAM MEMBERS' DATED SIGNATURES

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

DMAS 372, 8/04

Example form for DMAS purposes only. *This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.*

COMPREHENSIVE INDIVIDUAL PLAN OF CARE

30-DAY PROGRESS UPDATE

Resident Name:

Medicaid Number:

DSM-IV-Note any changes from the CIPOC:

Axis I
Axis II
Axis III
Axis IV
Axis V

Describe the Continued Need for Residential Level of Care (symptoms and behaviors that cannot be met at a lower level of care):

Describe recipient's involvement/cooperation in treatment:

LONG-TERM GOALS UPDATE:
Three measurable long-term goals with target dates for achievement and each with measurable treatment objectives/interventions (note if previous goals have been met, and if new goals have been established for unresolved or new problems):

1. _____
MEASUREABLE GOAL

_____
TREATMENT OBJECTIVE/INTERVENTION

_____
TARGET DATE FOR ACHIEVEMENT

2. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

SHORT-TERM GOALS UPDATE:

Three measurable short-term goals with target dates for achievement and each with measurable treatment objectives/interventions (note if previous goals have been met, and if new goals have been established):

1. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

2. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

3. _____

MEASUREABLE GOAL

_____

TREATMENT OBJECTIVE/INTERVENTION

_____

TARGET DATE FOR ACHIEVEMENT

Note Changes to Orders for Medications (note name, dosage and frequency):

Note Changes to Orders for Therapies (note type, frequency, duration):

Individual Therapy (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not):

Family Therapy (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not):

List any changes to the 21 therapeutic interventions:

Note any changes to Other Therapies (i.e. Group Psychotherapy, Occupational, Physical Therapy):

Note Any Additional Orders:

Summary of Progress and Justification for Continued Stay (if there is no progress, describe how treatment is being adjusted to address the lack of progress. If new problems have arisen, describe them and how the treatment plan will address them):

Note Changes to Discharge Plan (including estimated date of discharge):

Physician's Dated Signature

SIGNATURE	TITLE	DATE

TEAM MEMBERS' DATED SIGNATURES

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

DMAS 373, 8/04

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FAPT ASSESSMENT

At a minimum, the assessment must include the following:

IMMEDIATE AND LONG RANGE THERAPEUTIC NEEDS:

Developmental Priorities:

Personal Strengths:

Personal Liabilities:

Potential for Family Reunification:

Treatment Objectives:

Therapeutic Modalities:

At a minimum, 3 signatures are required.

FAPT TEAM MEMBER	DATE
FAPT TEAM MEMBER	DATE
FAPT TEAM MEMBER	DATE