



# Medical Necessity Criteria

## Louisiana Coordinated System of Care

Version 1.2

Effective Date: January 1, 2018

Revision Date: April 23, 2025

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## Preamble - Principles of Medical Necessity Determinations

### Individualized, Needs-Based, Least-Restrictive Treatment

Magellan <sup>1</sup> is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual patient's bio psychosocial needs. We see the continuum of care as a fluid treatment pathway, where patients may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active and takes into consideration the patient's stage of readiness to change/readiness to participate in treatment.

The level of care criteria that follow are guidelines for determining medical necessity based on the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5<sup>®</sup>) disorders. Individuals may at times seek admission to clinical services for reasons other than medical necessity, e.g., to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway/truant behavior, to achieve family respite, etc. However, these factors do not alone determine a medical necessity decision. Further, coverage for services is subject to the limitations and conditions of the member benefit plan. Specific information in the member's contract and the benefit design for the plan dictate which medical necessity criteria are applicable.

Although these Medical Necessity Criteria Guidelines are divided into "psychiatric" and "substance-related" sets to address the patient's primary problem requiring each level of care, psychiatric and substance-related disorders are often co-morbid. Thus, it is very important for all treatment facilities and providers to be able to assess these co-morbidities and address them along with the primary problem.

### Clinical Judgment and Exceptions

The Magellan Medical Necessity Criteria Guidelines direct both providers and reviewers to the most appropriate level of care for a patient. While these criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. As in the review of non-exceptional cases, clinical judgment consistent with the standards of good medical practice will be used to resolve these exceptional cases.

All medical necessity decisions about proposed admission and/or treatment, other than outpatient, are made by the reviewer after receiving a sufficient description of the current clinical features of the patient's condition that have been gathered from a face-to-face evaluation of the patient by a qualified clinician. Medical necessity decisions about each patient are based on the clinical features of the individual patient relative to the patient's socio-cultural environment, the medical necessity criteria, and the real resources available. We recognize that a full array of services is not available everywhere. When a medically

<sup>1</sup>In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc. – Employer Services. Other Magellan entities include Magellan Healthcare, Inc. f/k/a Magellan Behavioral Health, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Behavioral Health of Florida, Inc.; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc.; Magellan Providers of Texas, Inc.; and their respective affiliates and subsidiaries; all of which are affiliates of Magellan Health, Inc. (collectively "Magellan").

necessary level does not exist (e.g., rural locations), we will support the patient through extra-contractual benefits, or we will authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the patient's essential needs for safe and effective treatment.

## Medical Necessity Definition

Magellan reviews mental health and substance use disorder treatment for medical necessity. Magellan defines medical necessity as: "Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:

1. consistent with:
  - a. the diagnosis and treatment of a condition; and
  - b. the standards of good medical practice;
2. required for other than convenience; and
3. the most appropriate supply or level of service.

When applied to inpatient care, the term means: the needed care can only be safely given on an inpatient basis."

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

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

Magellan Medical Necessity criteria do not supersede state or Federal law or regulation, including Medicare National or Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

## Levels of Care & Service Definitions

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

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

### Hospitalization

- a. Hospitalization describes the highest level of skilled psychiatric and substance use disorder services provided in a facility. This could be a free-standing psychiatric hospital, a psychiatric unit of general hospital or a detoxification unit in a hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.

### Outpatient Treatment

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

### Term Definitions

1. Family:  
Individuals identified by an adult as part of his/her family or identified by a legal guardian on behalf of children. Examples would include parents/step-parents, children, siblings, extended family members, guardians, or other caregivers.
2. Support System:  
A network of personal (natural) or professional contacts available to a person for practical, clinical, or moral support when needed. Examples of personal or natural contacts would include friends, church, school, work and neighbors. Professional contacts would include wraparound agency, primary care physician, psychiatrist, psychotherapist, treatment programs (such as clubhouse, psychiatric rehabilitation), peer specialists, and community or state agencies.

### 3. Significant Improvement:

- a. Services provided at any level of care must reasonably be expected to improve the patient's condition in a meaningful and measurable manner. The expectation is that the patient can accomplish the following in the current treatment setting: continue to make measurable progress, as demonstrated by a further reduction in psychiatric symptoms, or
- b. Acquire requisite strengths in order to be discharged or move to a less restrictive level of care.
- c. The treatment must, at a minimum, be designed to alleviate or manage the patient's psychiatric symptoms so as to prevent relapse or a move to a more restrictive level of care, while improving or maintaining the patient's level of functioning. "Significant Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require a move to a more restrictive level of care, this criterion would be met.
- d. For most patients, the goal of therapy is restoration to the level of functioning exhibited prior to the onset of the illness. For other psychiatric patients, particularly those with long-term, chronic conditions control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable interpretation of "significant improvement".
- a. **Qualified Healthcare Professional:**  
An individual that is independently licensed and credentialed by and contracted with Magellan, who performs a service within their scope of practice as permitted by applicable state and/or federal law.
- b. **Physician:**  
Doctors of medicine (MD) and doctors of osteopathic medicine (DO) with an unrestricted license to practice medicine.
- c. **Adolescent**  
Experts generally agree that no one chronological age defines the end of adolescence. Rather, it is determined by considering a number of factors including chronological age, maturity, school and social status, family relationships, and living situation.
- d. **Standardized Screening Tools**  
Tools used for assessment include, but are not limited to, the Mini-Mental Status Examination (MMSE) and the Child and Adolescent Needs and Strengths (CANS) assessment.



## Hospitalization, Psychiatric, Child and Adolescent

### Criteria for Admission

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

#### I. Admission - Severity of Need

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

- A. The patient has a diagnosed or suspected psychiatric diagnosis. Presence of the illness (es) must be documented through the assignment of an appropriate DSM-5 diagnosis.
- B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.
- C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
  - 1) a current plan or intent to harm self with an available and lethal means, or
  - 2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, or
  - 3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, or
  - 4) other similarly clear and reasonable evidence of imminent serious harm to self.
- D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:
  - 1) a current plan or intent to harm others with an available and lethal means, or
  - 2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, or
  - 3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, or
  - 4) other similarly clear and reasonable evidence of imminent serious harm to others.

- E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

## II. Admission - Intensity and Quality of Service

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

- A. The evaluation and assignment of the psychiatric diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician no more than 24 hours prior to or 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance use disorder diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.
- C. The individualized plan of treatment includes plans for at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider shall be notified of the patient's current status to ensure care is coordinated. With proper consent, the Wraparound Agency shall be notified of the admission within 24 hours of the admission.
- E. Discharge planning shall be initiated at admission and finalized in collaboration with the Wraparound Agency and Magellan 24 hours before the scheduled discharge.
- F. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

## Criteria for Continued Stay

### III. Continued Stay

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

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

- 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or
- 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or
- 3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation or
- 4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

B. The current treatment plan includes documentation of a DSM-5 diagnosis, individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.

D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.

E. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment if clinically relevant and appropriate.

## Outpatient Treatment, Psychiatric, and Substance Use Disorders

### Criteria for Treatment Status Review

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for the treatment review.

#### I. Severity of Need

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

- A. The patient has, or is being evaluated for, a DSM-5 diagnosis.
- B. The presenting behavioral, psychological, and/or biological dysfunctions and functional impairment (occupational, academic, social) are consistent and associated with the DSM-5 psychiatric/substance-related disorder(s).
- C. One of the following:
  - 1) the patient has symptomatic distress and demonstrates impaired functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, academic, or social), that are the direct result of a DSM-5 diagnosis. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas, or
  - 2) the patient has a persistent illness described in DSM-5 with a history of repeated admissions to 24-hour treatment programs for which maintenance treatment is required to maintain community tenure, or
  - 3) there is clinical evidence that a limited number of additional treatment sessions are required to support termination of therapy, although the patient no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. Additionally, the treatment plan should include clear goals needing to be achieved and methods to achieve them in order to support successful termination (such as increasing time between appointments, use of community resources, and supporting personal success).
- D. The patient does not require a higher level of care.
- E. The patient demonstrates motivation to manage symptoms or make behavioral change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- F. The patient is capable of developing skills to manage symptoms or make behavioral change.

## II. Intensity and Quality of Service

Criteria A, B, C, D, E, F, G, H, I, J, and K must be met to satisfy the criteria for intensity and quality of service. In addition, L and M must also be met for substance use disorders.

- A. There is documentation of a DSM-5 diagnosis. The assessment also includes the precipitating event/presenting issues, specific symptoms and functional impairments, community and natural resources, personal strengths, and the focus of treatment.
- B. There is a medically necessary and appropriate treatment plan, or its update, specific to the patient's behavioral, psychological, and/or biological dysfunctions associated with the DSM-5 psychiatric/substance-related disorder(s). The treatment plan is expected to be effective in reducing the patient's occupational, academic or social functional impairments and:
  - 1) alleviating the patient's distress and/or dysfunction in a timely manner, or
  - 2) achieving appropriate maintenance goals for a persistent illness, or
  - 3) supporting termination.
- C. The treatment plan must identify all of the following:
  - 1) treatment modality, treatment frequency and estimated duration;
  - 2) specific interventions that address the patient's presenting symptoms and issues;
  - 3) coordination of care with other health care services, e.g., primary care provider or other behavioral health practitioners;
  - 4) the status of active involvement and/or ongoing contact with patient's family and/or support system, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible;
  - 5) the status of inclusion and coordination, whenever possible, with appropriate community resources;
  - 6) consideration/referral/utilization of psychopharmacological interventions for diagnoses that are known to be responsive to medication;
  - 7) documentation of objective progress toward goals for occupational, academic or social functional impairments, target-specific behavioral, psychological, and/or biological dysfunctions associated with the DSM-5 psychiatric/substance-related disorder(s) being treated. Additionally, specific measurable interim treatment goals and specific measurable end of treatment goals, or specific measurable maintenance treatment goals (if this is maintenance treatment), are identified. Appropriate changes in the treatment plan are made to address any difficulties in making measurable progress;
  - 8) the description of an alternative plan to be implemented if the patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are psychiatric evaluation if not yet obtained, a second opinion, or introduction of adjunctive or different therapies; and
  - 9) the current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria (I above). This evolving clinical status is documented by written contact progress notes.

- D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- E. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient, and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.
- F. Although the patient has not yet obtained the treatment goals, progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.
- G. Treatment is effective as evidenced by improvement in SF-BH, CHI, CANS, and/or other valid outcome measures.
- H. Requested services do not duplicate other provided services.
- I. The treatment plan shall be in harmony with the children's Plan of Care.
- J. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.
- K. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.
- L. For substance use disorders, treatment considers the use of medication-assisted treatment to address cravings and relapse prevention unless medically contraindicated.
- M. For substance use disorders, a Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction.

## Psychological Testing

### Criteria for Authorization

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

#### I. Severity of Need

Criteria A, B, and C must be met:

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

#### II. Intensity and Quality of Care

Criteria A, and B must be met:

- A. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), medical psychologist (M.P.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, administers the tests.
- B. Requested tests must be standardized, valid and reliable in order to answer the specific clinical question for the specific population under consideration. The most recent version of the test must be used, except as outlined in Standards for Educational and Psychological Testing.

#### III. Exclusion Criteria

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

- A. The testing is primarily for educational or vocational purposes.
- B. The testing is primarily for the purpose of determining if an individual is a candidate for a specific medication or dosage.

- C. The testing results could be invalid due to the influence of a substance, substance use disorder, substance withdrawal, or any situation that would preclude valid psychological testing results from being obtained (e.g., an individual who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered).
- D. Two or more tests are requested that measure the same functional domain.
- E. Testing is primarily for forensic (legal) purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing, or testing that is requested by an administrative body (e.g., a licensing board, Worker's Compensation, or criminal or civil litigation).
- F. Requested tests are experimental, antiquated, or not validated.
- G. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.
- H. The number of hours requested for the administration, scoring, interpretation and reporting exceeds the generally accepted standard for the specific testing instrument(s), unless justified by particular testing circumstances.
- I. Structured interview tools that do not have psychometric properties or normative comparisons.



# Inpatient Electroconvulsive Therapy

## Criteria for Authorization

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

### I. Severity of Need

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

- A. The clinical evaluation indicates that the patient has a DSM-5 diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.
- B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient’s medical status, the treatment history and the patient’s preference regarding treatment should be considered.
- C. One of the following:
  - 1) the patient has a history of inadequate response to adequate trial(s) of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); or
  - 2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; or
  - 3) the patient has a history of good response to ECT during an earlier episode of the illness, or
  - 4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.
- D. The patient’s status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

E. Either:

- 1) the patient is medically stable and requires the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, or
- 2) the patient does not have access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.

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

II. Intensity and Quality of Service

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

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

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

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

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

C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions that addresses:

- 1) specific medications to be administered during ECT, and
- 2) choice of electrode placement during ECT, and
- 3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.

D. There is continuous physiologic monitoring during ECT treatment, addressing:

- 1) seizure duration, including missed, brief and/or prolonged seizures, *and*
- 2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*
- 3) electrocardiographic activity, *and*
- 4) vital signs, *and*
- 5) oximetry, *and*
- 6) other monitoring specific to the needs of the patient.

E. There is monitoring for and management of adverse effects during the procedure, including:

- 1) cardiovascular effects, and
- 2) prolonged seizures, and
- 3) respiratory effects, including prolonged apnea, and
- 4) headache, muscle soreness and nausea.

F. There are post-ECT stabilization and recovery services, including:

- 1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, and
- 2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

## Criteria for Continued Treatment

### III. Continued Stay

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

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

- 1) the persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; or

- 2) the emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I; or
  - 3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.
- B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
- C. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.

# Community Psychiatric Support and Treatment (CPST)

## Criteria for Admission

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

### I. Admission – Severity of Need

Criteria A, B, and C must be met:

A. The member is unable to maintain an adequate level of functioning without this service due to a Psychiatric or substance use disorder as evidenced by (must meet 1 and either 2 or 3):

- 1) Severe symptoms and/or history of severe symptoms for a significant duration *and*
- 2) Impairment in performance of the activities of daily living, *and/or*
- 3) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.

B. The member seeks and actively participates in a joint provider/member assessment and the provider/member jointly agree that the member desires, is committed to, will likely benefit from the supportive/rehabilitation process.

C. The interventions necessary to reverse, stabilize or enhance the member's condition requires the frequency, intensity and duration of contact provided by the CPST provider as evidenced by:

- 1) Failure to reverse/stabilize/progress with a less intensive intervention *and/or*
- 2) Need for specialized intervention for a specific impairment or disability.

### II. Admission – Intensity and Quality of Service

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

A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of Psychiatric or substance use disorder symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

B. Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis to the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living, and

independent living skills to restore stability, to support functional gains and to adapt to community living.

- C. Participation in and utilization of, strengths-based planning and treatments, which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness. The treatment plan shall be informed by and in harmony with the Plan of Care.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk him or her remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.
- E. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems, including the Wraparound Agency, should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. The provider shall participate in Child and Family Team Process.
- F. School-based health services include covered BH services, treatment, and other measures to correct or ameliorate an identified mental health or substance use disorder diagnosis. Services are provided by or through a Local Education Agency (LEA) to children with, or suspected of having, disabilities who attend school in Louisiana.
- G. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

## Criteria for Continued Stay

### III. Continued Stay

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

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

## Community Brief Crisis Support (CBCS)

CBCS services are an ongoing crisis response intended to be rendered for up to 15 days and are designed to provide relief, resolution, and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers. The specific requirements for severity of need and components must be met to satisfy the criteria for admission. CBCS requires prior authorization, is based on medical necessity, and is intended to assure ongoing access to medically necessary crisis response services and supports until the current crisis is resolved or until the member can access alternative behavioral health supports and services.

### Criteria for Admission

#### I. Admission – Severity of Need

Criteria A, B, and C must be met:

- A. Services must be determined and recommended by an LMHP or physician.
- B. Rendered to eligible members after a referral is made from Magellan, Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), or Crisis Stabilization (CS) provider.
- C. All individuals or current physical caregivers of a minor who self-identify as experiencing a seriously acute psychological/emotional change, that results in a marked increase in personal distress, and which exceeds the abilities and the resources of those involved to effectively resolve it.

#### II. Admission – Components

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

- A. Screening, assessment, interventions, and care coordination shall be provided as outlined in the Mobile Crisis Response Section for Admission section of this manual.
- B. Follow-up shall be provided to the member and authorized member's caretaker and/or family within 24 hours as appropriate and desired by the member and up to 15 days following presentation to an emergency department for a reason related to emotional distress or initial contact with the CBCS provider once the previous crisis provider (MCR, BHCC, CS) has discharged the member to ensure continued stability post-crisis for those not accessing higher levels of care, including but not limited to:
  - 1) Telephonic or face-to-face follow-up based on clinical individualized need, with face-to-face follow-up highly preferred
  - 2) Additional calls/visits to the member following the crisis as indicated in order to stabilize the crisis, and if the member indicates no further communication is desired, it must be documented in the member's record.

- C. Services shall be delivered in a culturally and linguistically competent manner.
- D. The CBCS provider must contact the youth's Wraparound Agency following the initiation of the service so that the treatment plan is in harmony with the member's Plan of Care and make every effort to coordinate with the assigned Wraparound Facilitator.

### **III. Exclusion Criteria**

- A. CBCS services are not delivered in SUD residential facilities, PRTF, or inpatient facilities;
- B. Services are not delivered for incarcerated individuals; and are not
- C. Utilized as step-down services from other residential or inpatient psychiatric service settings.

### **Criteria for Continued Treatment**

#### **IV. Continued Treatment**

CBCS provider will resource the member up to 15 days. Members are eligible for ongoing crisis services as long as medical necessity is met and the member is not already linked to an existing MHR or ACT provider.



## Crisis Intervention, Psychiatric

Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CIs are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school, and/or socializes.

### Criteria for Admission

An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis, and this will not, in and of itself, disqualify them for eligibility for the service. Crisis Intervention services may be provided for emergent situations without the need for prior authorization. Additional units may be approved with prior authorization if necessary.

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

#### I. Admission – Severity of Need

Criteria A and B must be met:

- A. The individual must be experiencing a seriously acute psychological or emotional crisis, resulting in a significant increase in distress that exceeds their ability and available resources to resolve the crisis independently.
- B. The individual self-identifies as experiencing this crisis.

#### II. Admission – Intensity and Quality of Service

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

- A. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services includes but is not limited to the following:
  - 1) Contact with the member, family members, Wraparound Agency, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment *and/or*
  - 2) Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care *and/or*
  - 3) Referral to other alternative mental health services at an appropriate level may be considered.

- B. Short-term Crisis Interventions (CI), including crisis resolution and debriefing with the identified Medicaid-eligible individual.
- C. Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members to ensure stabilization and connection to appropriate resources.
- D. Consultation with a physician or with other qualified providers to assist with the individual's specific crisis.
- E. The assessment of risk, mental status and medical stability must be completed by an LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license.
- F. The treatment plan shall be in harmony with the [child's](#) Plan of Care.
- G. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum, shall have monthly contact with the wraparound facilitator working with the youth and family.

## Criteria for Continued Stay

### III. Continued Stay

Criteria A, B, and C must be met:

- A. The member continues to meet admission criteria for Crisis Intervention services, and the current crisis is not resolved.
- B. Despite reasonable therapeutic efforts, the clinical evidence indicates the need for at least one of the following:
  - 1) Short-term Crisis Intervention, including crisis resolution and debriefing with the identified Medicaid-eligible individual or
  - 2) Follow up with the individual and, as necessary, with the individual's caretaker and/or family members *or*
  - 3) Consultation with a physician or with other qualified providers to assist with the individual's specific crisis.
- C. The assessment of risk; mental status and medical stability must be completed by an LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license.

## FAMILY FUNCTIONAL THERAPY (FFT)

### Criteria for Admission

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

#### I. Admission – Severity of Need

Criteria A, B, and C must be met:

- A. Externalizing behaviors symptomatology which adversely affects family functioning or functioning in other systems, resulting in a DSM-5 diagnosis of disruptive behavior disorder (ADHD, oppositional defiant disorder, and/or conduct disorder). Other diagnoses may be accepted as long as the existing mental health and behavioral health issues manifest in outward behaviors that impact the family and multiple systems.
- B. Referred by other service providers and agencies on behalf of the youth and family, though other referral sources also are appropriate.
- C. At least one adult caregiver is available to provide support and is willing to be involved in treatment.

#### II. Admission – Intensity and Quality of Service

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

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

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

F. The treatment plan shall be in harmony with the child's Plan of Care.

G. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

### III. Exclusion Criteria

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

- A. Youth has a functional impairment not solely as a result of autism spectrum disorder or intellectual disability.

### Criteria for Continued Stay

#### IV. Continued Stay

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

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

# Homebuilders

## Criteria for Admission

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

### I. Admission – Severity of Need

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

A. Children returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities, with at least one or more of the following:

1. Children/youth with serious behavioral and/or emotional problems in the home, school, and/or community;
2. Family members with substance abuse problems, mental health problems, poverty-related concerns (lack of adequate housing, clothing and/or food);
3. Babies that were born substance-exposed or considered failure to thrive
4. Teenagers/adolescents that run away from home, have suicidal risk, have attendance and/or behavioral problems at school, have drug and alcohol use, and/or experience parent-teen conflict(s);
5. Children/youth who have experienced abuse, neglect, or exposures to violence or other trauma

B. Children with serious behavior problems at home and/or school with at least one of the following:

1. Caregiver and/or child emotional/behavioral management problems
2. Trauma exposure
3. Incurability
4. Academic problems
5. Delinquency
6. Truancy
7. Running away
8. Family conflict and violence
9. Poor/ineffective parenting skills
10. Single-parent families
11. Sibling antisocial behavior
12. Parental/caregiver use of physical punishment, harsh, and/or erratic discipline practices
13. Substance use
14. Mental health concerns (depression/mood disorders, anxiety, etc.)
15. Additional topics such as: poverty, lack of education, substandard housing, lack of supports and resources

### II. Admission – Intensity and Quality of Service

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

- A. Provide services for four to six weeks of intensive intervention with up to two “booster sessions”.
- B. Services are strengths-based, and goals are aimed at effective parenting, improved family environment, improved child/adolescent behavior, and pro-social family involvement.
- C. Treatment provides the following support and services within the family’s home and community:
  - 1) Availability of services for Crisis Intervention 24 hours a day, seven days a week
  - 2) Completes collaboratively with each family an assessment of family strengths, problems, and barriers to service/treatment and outcome-based goals and treatment plans
  - 3) Employ research-based treatment practices such as motivational interviewing, behavioral parent training, CBT strategies, and relapse prevention
  - 4) Identification of formal and informal support systems, develop and enhance supports and resources for maintaining and facilitating changes.
- D. The treatment plan shall be in harmony with the child’s Plan of Care.
- E. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

## Criteria for Continued Stay

### IV. Continued Stay

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

- A. Family/child and services continue to meet the admission criteria defined above.
- B. There is reasonable expectation that the family/child will benefit for the continuation of the services.
- C. Treatment promotes developmentally appropriate behavior, activities, skills, and social skills

for the child in his/her natural context through focusing on his or her individual strengths and needs.

- D. Interventions are employed in the treatment plan that are time-limited in nature and subordinate to a goal of enhanced autonomy and family functioning.
- E. Appearance of new problems or symptoms which meet admission criteria.
- F. The child requires the continuation of a treatment while in the community until an effective family and community support network can be activated.

## Mobile Crisis Response (MCR)

MCR is an initial crisis response and is allowed without the requirement of a prior authorization in order to address the emergent issues in a timely manner, although providers are required to notify Magellan when a member presents as needing this service. MCR is intended to provide crisis supports and services during the first 72 hours of a crisis. Services are not intended to substitute for already approved and accessible home and community-based interventions as included in the plan of care (POC) and should not be utilized as step-down services from residential or inpatient psychiatric or Substance Use Disorder (SUD) treatment facilities. The specific requirements for severity of need and components must be met to satisfy the criteria for admission.

### Criteria for Admission

#### I. Admission – Severity of Need

Criteria A and B must be met:

- A. Services must be determined and recommended by an LMHP or physician.
- B. For minors under the age of 18, eligibility for initial/emergent crisis services based on “self-identification” that the member is experiencing a crisis includes self-identification by the minor and identification by the current physical caregiver to the minor, under the principle that “the crisis is defined by the caller.” The caller, who identifies the crisis and initiates MCR services for the minor, may commonly be an adult currently serving in a caregiving role to the minor in the setting where the crisis is being experienced. Caregivers may include but are not limited to:
  - 1) Caregivers in a home setting, including a parent, person with legal authority to act on the minor’s behalf, foster parent, fictive kin, or other family member serving in a caregiving role in the home or community setting at the time that the minor is experiencing the crisis;
  - 2) Teacher or staff in a school setting where the minor is experiencing a crisis;
  - 3) Care staff at a group home setting where the minor currently resides and where the minor is experiencing the crisis; or
  - 4) Helping professional accompanying the minor at the time of the crisis, such as a pediatrician, FINS worker, or probation officer.

#### II. Admission – Components

Criteria A, B, C, D, E, F, G, H, I, J, K, and L must be met:



- A. A brief preliminary, person-centered screening of risk, mental status, medical stability and the need for further evaluation or other mental health services shall be conducted, which includes but is not limited to the following:
  - 1) Contact with the member, family members, Wraparound Agency, or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary screening and/or referral to and coordination with other alternative behavioral health services at an appropriate level; and
  - 2) When a member is referred by another crisis provider, the screening of risk, mental status, and medical stability and the need for further evaluation or other mental health services builds on the screening and assessments conducted by the previous crisis service providers.
- B. If further evaluation is needed, an assessment must be conducted by a licensed mental health professional (LMHP) or psychiatrist, unless otherwise specified with experience regarding this specialized mental health service and shall include:
  - 1) Contact with the member, family members, or other collateral sources with pertinent information for the purpose of the assessment and/or referral to and coordination with other alternative behavioral health services at an appropriate level.
  - 2) If the member expressly refuses to include family or other collateral sources, this must be documented in the member record.
  - 3) When a member is referred by another crisis provider if further evaluation is needed, the assessment builds on the screening or assessments conducted by the previous crisis service providers.
- C. Interventions are driven by the member and the person with parental authority whose minor is in crisis and shall include resolution-focused treatment, peer support, safety planning, service planning, and care coordination designed to de-escalate the crisis and strategies are developed for the member to use post-crisis to mitigate the risk of future incidents until engaged in alternative services, if appropriate.
- D. Interventions must be provided under the supervision of a licensed mental health professional (LMHP) or psychiatrist unless otherwise stated, who is acting within the scope of their professional license and applicable state law.
- E. Short-term goals are set to ensure stabilization, symptom reduction, and restoration to a previous level of functioning.
- F. Support, education, and consultation are provided to the member, family, and collateral supports.

- G. Substance use is recognized and addressed in an integrated fashion, as it may contribute to risk and increase the need for engagement in care.
- H. Crisis providers shall coordinate care for the member following the crisis event as needed.
- I. Services shall be delivered in a culturally and linguistically competent manner.
- J. MCR providers are dispatched after an initial triage screening determines that MCR is the most appropriate service.
- K. Follow-up is provided to the member and authorized member's caretaker and/or family within 24 hours as appropriate and desired by the member and up to 72 hours to ensure continued stability post-crisis for those not accessing higher levels of care or another crisis service, including but not limited to:
  - 1) Telephonic or face-to-face follow-up based on clinical individualized need, with face-to-face follow-up highly preferred for service delivery
  - 2) Additional calls/visits to the member following the initial crisis response as indicated to stabilize the individual in the aftermath of the crisis, documenting when the member request no further treatment is desired.
- L. The MCR provider must contact the youth's Wraparound Agency following the initiation of the crisis so that the treatment plan is in harmony with the member's Plan of Care and make every effort to coordinate with the assigned Wraparound Facilitator.

### III. Exclusion Criteria

- A. MCR services are not delivered in SUD residential facilities, PRTF, or inpatient facilities;
- B. Services are not delivered for incarcerated individuals; and are not
- C. Utilized as step-down services from other residential or inpatient psychiatric service settings.

### Criteria for Continued Treatment

#### IV. Continued Treatment

MCR provider will resource the youth for the initial 72 hours of the crisis only. Crisis care shall continue until the crisis is resolved, the member has met with the accepting behavioral health treatment provider of ongoing care, or until the member no longer needs crisis services.

## Multi-Systemic Therapy (MST)

MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. Depression and other disorders are considered, as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet criteria, and MST is deemed clinically more appropriate than focused drug and alcohol treatment. The specific requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission of youth targeted between the ages of 12 to 17.

### Criteria for Admission

#### I. Severity of Need

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

- A. Youth exhibits significant externalizing behavior, such as chronic or violent juvenile offenses;
- B. Youth is at risk for out-of-home placement or is transitioning back from an out-of-home setting;
- C. Youth exhibits externalizing behaviors symptomatology, resulting in a DSM-5 diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (oppositional defiant disorder, other disruptive, impulse-control, and conduct disorders, etc.);
- D. Ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems;
- E. Less intensive treatment has been ineffective or is inappropriate; or
- F. The youth's treatment planning team or Child Family Team (CFT) recommends that they participate in MST.

#### II. Intensity and Quality of Service

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

- A. A youth receives MST for 3 to 5 months,
- B. The MST therapist meets with the youth or family at least weekly, but often multiple times per week, depending on need.
- C. Services occur in the family's home or community at times that are convenient for the family.
- D. Services include assessment; ongoing treatment planning; family therapy; parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment

goals); consultation to and collaboration with other systems, (i.e., school, juvenile probation, children and youth and job supervisors); individual therapy may occur (but is not the primary mode of treatment); and if needed, referral for psychological assessment, psychiatric evaluation, and medication management.

- E. All treatment planning is informed by an initial psychosocial assessment, which is completed by the MST Supervisor prior to entry into MST services.
- F. Treatment planning is conducted by MST therapist using the MST “Case Summary” process.
- G. MST treatment is attuned to the importance of ethnicity and culture for all members referred for services.
- H. The treatment plan shall be in harmony with the child’s Plan of Care.
- I. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

### III. Exclusion Criteria

MST services may not be clinically appropriate for individuals who meet the following conditions:

- A. Youth referred primarily due to concerns related to suicidal, homicidal or psychotic behavior;
- B. Youth living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers;
- C. The referral problem is limited to sexual offending in the absence of other delinquent or antisocial behavior;
- D. Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;
- E. Low-level need cases; or
- F. Youth who have previously received MST services or other intensive family- and community-based treatment.

**\* Exception – Member may be allowed an additional course of treatment if all of the following criteria are met:**

- 1) MST program eligibility criteria are currently met;
- 2) Specific conditions have been identified that have changed in the youth’s ecology, compared to the first course of treatment,

- 3) It is reasonably expected that successful outcomes could be obtained with a second course of treatment; and
- 4) Program entrance receives prior authorization by Magellan.

**Note:** MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These services may be provided and billed separately for a member receiving MST services. MST shall not be billed in conjunction with the following services:

- 1) BH services by licensed and unlicensed individuals, other than medication management and assessment; and
- 2) Residential services, including professional resource family care. Magellan will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs). These are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions.

## Criteria for Continued Treatment

### IV. Continued Treatment

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

- A. Treatment does not require more intensive level of care;
- B. The treatment plan has been developed, implemented and updated based on the youth's clinical condition and response to treatment, incorporating the strengths of the family, with realistic goals and objectives clearly stated;
- C. Progress is clearly evident in objective terms, although the goals of treatment have not yet been achieved, or adjustments in the treatment plan are evident to address any lack of progress; and
- D. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

## Criteria for Discharge from Services

### V. Discharge

Youth who meet the following criteria no longer meet medical necessity criteria for MST and shall be discharged from MST treatment:

- A. The member's treatment plan goals or objectives have been substantially met;

- B. The member meets criteria for a higher or lower level of treatment, care or services;
- C. The member's, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment; and
- D. Consent for treatment has been withdrawn, or youth and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

# Psychosocial Rehabilitation

## Criteria for Admission

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

### I. Admission – Severity of Need

Criteria A, B, and C must be met:

A. Inadequate level of functioning without this service due to a psychiatric or substance use disorder as evidenced by (must meet A and either B or C):

- 1) Severe symptoms and/or history of severe symptoms for a significant duration *and*
- 2) Impairment in performance of the activities of daily living *and/or*
- 3) Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.

B. The member seeks and actively participates in a joint provider/member assessment and the provider/member jointly agree that the member desires, is committed to, will likely benefit from the rehabilitation process.

C. The interventions necessary to reverse, stabilize or enhance the member's condition requires the frequency, intensity and duration of contact provided by the rehabilitative service as evidenced by:

- 1) Failure to reverse/stabilize/progress with a less intensive intervention *and/or*
- 2) Need for specialized intervention for a specific impairment or disability.

### II. Admission – Intensity and Quality of Service

Criteria A through G must be met.

A. Services are to develop social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school.

B. Services are to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

- C. Services teach learned skills so the person can remain in a natural community location and achieve developmentally appropriate functioning.
- D. Services are to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- E. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- F. The treatment plan shall be in harmony with the child's Plan of Care.
- G. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

## Criteria for Continued Stay

### III. Continued Stay

Criteria A, B, and C must be met.

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



## Crisis Stabilization

### Admission - Severity of Illness

Criteria A & B must be met.

- A. Must have a primary psychiatric DSM-5 diagnosis or symptomology consistent with a DSM-5 diagnosis *and*
- B. Member is experiencing a crisis that places him/her at risk of psychiatric inpatient or institutional treatment.

### Admission – Intensity and Quality of Service

Criteria A through F must be met.

- A. Crisis stabilization is intended to provide short-term and intensive supportive resources for the youth and his/her family. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crises.
- B. During the time the crisis stabilization is supporting the youth, there is regular contact with the family to prepare for the youth's return and his/her ongoing needs as part of the family.
- C. The youth, family, and crisis stabilization provider are integral members of the youth's individual treatment team.
- D. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- E. The treatment plan shall be in harmony with the child's Plan of Care.
- F. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

### Admission – Exclusionary Criteria

- A. Crisis stabilization shall not be provided simultaneously with short-term respite care.

### Criteria for Continued Stay

Criterion A must be met.

- B. Member continues to be at risk of psychiatric inpatient or institutional treatment.

## Assertive Community Treatment (ACT)

### Criteria for Admission

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

#### I. Admission – Severity of Need

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

- A. The patient is diagnosed with Schizophrenia, Other Psychotic Disorder, Bipolar Disorder and/or Major Depressive Disorder. These disorders may be accompanied by Substance Use Disorder or Developmental Disability
- B. Must be 18 years of age or older.
- C. One or more of the following:
  - 1. Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months.
  - 2. Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life.
  - 3. Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.
- D. One of the following:
  - 1. Inability to participate or remain engaged or respond to traditional community-based services or
  - 2. Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless
- E. Three of the following:
  - 1. Evidence of co-existing mental illness and substance use disorder
  - 2. Significant suicidal ideation, with a plan and ability to carry out within the last two years
  - 3. Suicide attempt in the last two years
  - 4. History of violence due to untreated mental illness / substance use within the last two years
  - 5. Lack of support systems
  - 6. History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability
  - 7. Threats of harm to others in the past two years
  - 8. History of significant psychotic symptomatology, such as command hallucinations to harm others
  - 9. Minimum LOCUS score of 3

## Admission – Intensity and Quality of Service

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

- A. Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in crisis intervention (CI) procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone.
- B. Provide mobilized crisis intervention in various environments, such as the recipient's home, schools, jails, homeless shelters, streets and other locations.
- C. Arrange or assist consumers to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home.
- D. Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff.
- E. Ensure provision of culturally competent services.
- F. The teams will provide the following supports and services to consumers:
  - 1. Needs assessment and individualized care plan development: This will include items relevant for any specialized interventions, such as linkages with the forensic system for consumers involved in the judicial system. In particular, the assessment will include items related to court orders, identified within 30 days of admission and updated every 90 days or as new court orders are received.
  - 2. Crisis assessment and intervention.
  - 3. Symptom management and mediation.
  - 4. Individual counseling.
  - 5. Medication administration, monitoring, education and documentation.
  - 6. Skills training in activities related to self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities.
  - 7. Social skills training necessary for functioning in a work, educational, leisure or other community environment.
  - 8. Peer support.
  - 9. Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management.
  - 10. Referral and linkage or direct assistance to ensure that individuals obtain the basic necessities of daily life, including medical, social and financial supports.
  - 11. Education, support and consultation to individuals' families and other major supports.
  - 12. Monitoring and follow-up to help determine if psychiatric, substance use, mental health support and health related services are being delivered, as set forth in the care plan, adequacy of services in the plan and changes, needs or status of consumer.
  - 13. The team will assist the consumer in applying for benefits. This includes Social Security Income, Medicaid and Patient Assistance Program enrollment.
  - 14. For those members with forensic involvement, the team will liaise with the forensic coordinators, providing advocacy, education and linkage with the criminal justice system to ensure the consumer's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.

15. Assessments of the following must be completed within the first 30 days of admission.

- a. Psychiatric history, status and diagnosis.
- b. Level of Care Utilization System (LOCUS).
- c. Telesage Outcomes Measurement System, as appropriate.
- d. Psychiatric evaluation.
- e. Housing and living situation.
- f. Vocational, educational and social interests and capacities.
- g. Self-care abilities
- h. Family and social relationships.
- i. Family education and support needs.
- j. Physical health.
- k. Alcohol and drug use.
- l. Legal situation.
- m. Personal and environmental resources

- G. The LOCUS, psychiatric evaluation, and treatment plan will be updated every six months. The treatment plan shall be informed by and in harmony with the Plan of Care. A final LOCUS score must be completed prior to discharge.
- H. Services provided to children and youth must include communication and coordination with the family and/or legal guardian (when applicable). Coordination with other member-serving systems, including the Wraparound Agency, should occur, as needed, to achieve the treatment goals. All coordination must be documented in the member's medical record. The provider shall participate in Child and Family Team Process.
- I. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the member and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the member and family.

### Continued Stay Criteria:

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

- A. The member continues to meet admission criteria.
- B. Recovery requires a continuation of these services.
- C. Member, and family as appropriate, are making progress toward goals and actively participating in the interventions.
- D. Service continues to be recommended on member's Wraparound Plan of Care.
- E. There is a reasonable expectation of substantial benefit from the continued involvement of the ACT team. This is demonstrated by an observable positive response in the following areas of:
  - a. Medication Adherence
  - b. Reduction in the use of crisis services (If indicated as an issue in the treatment plan)

- c. Reduction in the use of inpatient episodes, and/or days spent in inpatient care, as compared to admission baseline figures.
- d. Enhancement of Social and Recreational skills (Improved communication and appropriate interpersonal behaviors)
- e. Improvement in activities of daily living; Improvement in the individual's community supports (Health, Legal, Transport, Housing, Finances, etc.)
- f. Enhancement of vocational skills or vocational readiness, as indicated.

## Parent Support & Training

### Criteria for Admission

#### I. Admission - Severity of Illness

Criteria A & B must be met.

- A. Meets functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. If beyond first 30 days of CSoc eligibility, service must be recommended on Plan of Care.

#### II. Admission - Intensity & Quality of Service

Criteria A through G must be met.

- A. Assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the eligible child/youth in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms and strategies for the child's/youth's symptom/behavior management.
- B. Assist the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care (POC) process.
- C. Train on understanding the child's diagnoses.
- D. Understand service options offered by service providers and assisting with understanding policies, procedures, and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other child-serving systems).
- E. The specialist may also conduct follow-up with the families regarding services provided and continuing needs.
- F. The treatment plan shall be in harmony with the child's Plan of Care.
- G. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

## Criteria for Continued Stay

Criteria A & B must be met.

- A. Continues to meet functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. Service continues to be recommended on Plan of Care.

## Youth Support & Training

### Criteria for Admission

#### I. Admission - Severity of Illness

Criteria A & B must be met.

- A. Meets functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. If beyond first 30 days of CSoc eligibility, service must be recommended on Plan of Care.

#### II. Admission - Intensity & Quality of Service

Criteria A through H must be met.

- A. Help the child/youth to develop a network for information and support from others who have been through similar experiences.
- B. Assist the child/youth to regain the ability to make independent choices and take a proactive role in treatment, including discussing questions or concerns with their clinician about medications, diagnoses or treatment.
- C. Assist the child/youth to identify, and effectively respond to or avoid, identified precursors or triggers that maintain or increase functional impairments.
- D. Assist the child/youth with the ability to address and reduce the following behaviors, reducing reliance on YSAT over time: rebellious behavior, early initiation of antisocial behavior (e.g., early initiation of drug use, shoplifting, truancy), attitudes favorable toward drug use (including perceived risks of drug use), antisocial behaviors toward peers, contact with friends who use drugs, gang involvement and intentions to use drugs.
- E. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Time spent in coordination activities is not billable time. However, there is a factor for coordination built into the rates.
- F. The YSAT provider must be supervised by a person meeting the qualifications for an YSAT supervisor (i.e., having at least a bachelor's degree and required OBH training) and a licensed mental health professional.
- G. The treatment plan shall be in harmony with the child's Plan of Care.
- H. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.



## Criteria for Continued Stay

Criteria A & B must be met.

- A. Continues to meet functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. Service continues to be recommended on Plan of Care.

## Independent Living Skills Building

### Admission - Severity of Illness

Criteria A & B must be met.

- A. Meets functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. If beyond first 30 days of CSoC eligibility, service must be recommended on Plan of Care.

### Admission - Intensity & Quality of Service

Criteria A through E must be met.

- A. Assist children who, are or will be, transitioning to adulthood with support in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to be successful in the domains of employment, housing, education and community life and to reside successfully in home and community settings.
- B. Services are individualized according to each youth's strengths, interests, skills, goals and are included on an individualized Plan of Care.
- C. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- D. The treatment plan shall be in harmony with the child's Plan of Care.
- E. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

### Criteria for Continued Stay

Criteria A & B must be met.

- A. Continues to meet functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. Service continues to be recommended on Plan of Care.

## Short Term Respite Care

### Admission - Severity of Illness

Criteria A & B must be met.

- A. Meets functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. If beyond first 30 days of CSoC eligibility, service must be recommended on Plan of Care.

### Admission – Intensity and Quality of Service

Criteria A through F must be met.

- A. Short term respite care provides temporary direct care and supervision for the child/youth in the child's home or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility).
- B. Respite services help de-escalate stressful situations and provide a therapeutic outlet for the child.
- C. Respite may be either planned or provided on an emergency basis.
- D. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record
- E. The treatment plan shall be in harmony with the child's Plan of Care.
- F. The provider shall make every effort to participate in regularly scheduled Child and Family Team meetings with the child/youth and family/natural supports as best practice, but at a minimum shall have monthly contact with the wraparound facilitator working with the youth and family.

## Admission – Exclusionary Criteria

- A. Short-Term Respite shall not be provided simultaneously with crisis stabilization.

## Criteria for Continued Stay

Criteria A & B must be met.

- A. Continues to meet functional assessment criteria for target population under the 1915 (b3) or 1915 (c) waiver.
- B. Service continues to be recommended on Plan of Care.

## Transcranial Magnetic Stimulation Treatment (TMS)

Transcranial magnetic stimulation (TMS) may be considered for treatment of major depressive disorder for adults who, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate TMS treatment. The treating psychiatric provider must demonstrate that the patient's symptoms are treatment-resistant to both a course of medication management and a course of psychotherapy. Resistance to treatment is defined in this guideline as a failure to achieve a fifty percent (50%) reduction in depressive symptoms after adequate trials of antidepressant therapy and evidence-based psychotherapy. Standardized rating scales that reliably measure depressive symptoms must be used to document both severity of illness and response to treatment.

### Criteria for Authorization

#### I. Severity of Need

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

A. The patient has a confirmed DSM-5 diagnosis of major depressive disorder, severe (single or recurrent episode) documented by standardized rating scales that reliably measure depressive symptoms.

B. Is used only for adults 18 years or older who are not pregnant.

C. Failure or intolerance to psychopharmacologic agents, choose ONE of the following:

1) Failure of psychopharmacologic agents, BOTH of the following:

a. Lack of clinically significant response in the current depressive episode to four trials of agents from at least two different agent classes; AND

b. At least two of the treatment trials were administered as an adequate course of mono- or poly-drug therapy with antidepressants, involving standard therapeutic doses of at least six weeks duration.

2) The member is unable to take anti-depressants due to ONE of the following:

a. Drug interactions with medically necessary medications; OR

b. Inability to tolerate psychopharmacologic agents, as evidenced by trials of four such agents with distinct side effects in the current episode; AND

D. No contraindications to TMS are present; AND

E. Electroconvulsive therapy has previously been attempted, is medically contraindicated, or has

been offered and declined by the member.

## II. Exclusion Criteria

The use of TMS in patients with any of the following is considered not reasonable and necessary (ALL of the following are absent):

- A. Seizure disorder or any history of seizures (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence or any condition or treatment that may lower the seizure threshold); or
- B. Presence of acute or chronic psychotic symptoms or disorders, such as schizophrenia, schizophreniform disorder, or schizoaffective disorder, in the current depressive episode;
- C. Neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system.
- D. Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 cm from the TMS magnetic coil or other implanted metal items including, but not limited to a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, vagus nerve stimulator (VNS), or metal aneurysm clips or coils, staples or stents.
- E. Concomitant esketamine intranasal, ketamine infusion or other infusion therapies for major depressive disorder.
- F. Used for maintenance therapy, continuous therapy, rescue therapy or extended active therapy as these are not supported by controlled clinical trials and are therefore considered not reasonable and necessary.
- G. TMS is considered investigational as a treatment of all other psychiatric and neurologic disorders, including but not limited to any of the following: bipolar disorder; migraine headaches, obsessive-compulsive disorder; schizophrenia.
- H. Substance use at the time of treatment.
- I. Diagnosis of severe cardiovascular disease.

## III. Intensity and Quality of Service

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

- A. TMS is reasonable and necessary for up to thirty (30) visits over a seven (7) week period, followed by six (6) tapered treatments. The number of treatments is evaluated against patient response and the published evidence-based literature. If medically necessary and appropriate for a member, additional sessions will be authorized.
- B. The order for treatment (or retreatment) is written by a psychiatrist who has examined the patient and reviewed the record. The psychiatrist will have experience in administering TMS therapy. The treatment shall be given under the direct supervision of this psychiatrist, i.e., the physician must be present in the area but does not necessarily personally provide the treatment.
- C. Physician and non-physician treating personnel must meet all provider qualifications, training, expectations, and documentation requirements.
- D. Treatment must be provided by use of a device approved or cleared by the FDA for the purpose of supplying TMS for these indications.
- E. Standardized rating scales that reliably measure depressive symptoms must be used to document severity of illness and response to treatment. These rating scales include:
  - 1) The Personal Health Questionnaire Depression Scale (PHQ-9)
  - 2) The Beck Depression Inventory (BDI)
  - 3) The Montgomery-Asberg Depression Rating Scale (MADRS)
  - 4) Geriatric Depression Scale (GDS)
  - 5) The Quick Inventory of Depressive Symptomatology (QIDS)
  - 6) The Hamilton Rating Scale for Depression (HAM-D)
  - 7) The Inventory for Depressive Symptomatology Systems Review (IDS-SR)

## Criteria for Continued Treatment

### IV. Continued Stay

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

- A) Patient met guidelines for initial treatment and subsequently developed relapse of depressive symptoms which have worsened by 50% from the prior best response of the PHQ-9 score.
- B) Patient responded to prior TMS treatments as evidenced by a greater than fifty percent (50%) improvement in standard rating scale measurements for depressive symptoms.
- C) Retreatment is not requested as maintenance therapy or continuous therapy. The time between treatment episodes should allow for assessment clinically and by one of the aforementioned rating scales to clearly document that the patient responded and then relapsed, typically three

(3) months since the last TMS session.

- D) If the patient meets the relapse criteria, up to thirty (30) visits for treatment followed by an additional six (6) visits for tapering is considered reasonable and necessary. The number of treatments is evaluated against patient response and the published evidence-based literature. If medically necessary and appropriate for a member, additional sessions will be authorized.