

# **CT Behavioral Health Partnership – Child Psychiatric Level of Care Guidelines**

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## Guidelines for Making Level of Care Decisions

These Level of Care guidelines are designed to assist care managers and providers in assessing a child's/adolescent's clinical presentation and determining the appropriate level of care. This document should be used as a guideline for facilitating access to the treatment setting and interventions based on a child's/adolescent's severity of illness and intensity of service need. In general, children/adolescents should be placed in the least restrictive level of care that is warranted by the severity of presenting symptoms, degree of functional impairment and environmental circumstances. The level of treatment intervention should match the presentation that necessitated the intervention. The ASO will allow for multiple levels of care to be authorized concurrently for the purpose of treatment continuity and flexibility in service planning. In all cases, the ASO will give due consideration to family/caregiver choice and the provider's expertise and will engage in a highly collaborative care decision-making process with providers and families/caregivers.

These guidelines are governed by the definitions of "medical necessity" and "EPSDT" (for children under twenty-one (21)) included at the end of this document. Costs may be factored into decision-making only when two alternative treatments are equally effective.

### A. Application of the Criteria

The application of the severity of illness criteria may be influenced by a variety of factors related to the child's/adolescent's psychiatric condition and living environment. Aspects of a child's/adolescent's condition that might warrant consideration in making level of care decisions include the following:

- Co-morbid psychiatric conditions
- Co-morbid substance abuse conditions
- Co-morbid developmental disabilities
- Co-morbid biomedical conditions
- Persistence of symptoms
- Relapse potential
- Prevalence of risk behaviors and victimization issues

Environmental factors that may influence level of care decisions include:

- Residence (e.g., home, shelter, residential center)
- Family/Caregiver functioning
- Major life events
- Abuse/neglect
- Treatment motivation
- Educational functioning

Although admission and continued care decisions should not be made solely on the basis of environmentally based risk, these factors need to be considered in treatment planning. Environmentally based factors may provide the impetus for continuing services or for facilitating access to a higher or lower level of care. Strengths and protective factors should be considered in all care decision making.

When clinical presentation supports more than one level of care, the intensity of service need, prior treatment history and the presence of protective factors are used to determine the most appropriate level of care.

## **B. Mitigating Factors**

Although efforts should always be made to review a child's/adolescent's course of treatment and level of care determination based on clinical and environmental factors listed above, there are particular events that might require a decision that falls out of the parameters listed above. Special consideration may be made for the following circumstances:

- Court ordered evaluation or treatment.
- The level of care that the child/adolescent needs and is eligible for is currently not available and the child's/adolescent's safety and well being requires placement in an alternative level of care, irrespective of clinical need.
- There is limited availability of the identified community provider network and to discharge out of one level of care to a less restrictive level of care without these identified supports in place would place the child/adolescent at risk for clinical deterioration.

## **C. Medicaid Definitions**

1. Medical Necessity - For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
2. EPSDT – Connecticut Medicaid recipients under the age of twenty one (21) are entitled to the benefits of the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program which includes an age-appropriate behavioral health and developmental assessment and any medically necessary follow-up treatment.

The Medical ASO is responsible for ensuring the provision of an assessment of individuals under the age of twenty-one (21). A child/adolescent may then be referred to either the Medical or Behavioral Health ASO for an inter-periodic screen by a professional who comes in contact with a child/adolescent outside of the formal health care system. The behavioral health ASO is responsible for ensuring the provision of an inter-periodic assessment of a child's/adolescent's behavioral health when a child/adolescent is referred either directly to a behavioral health provider in the CMAP network or to a Behavioral Health ASO care manager.

The behavioral health ASO's care managers or other behavioral health ASO staff must authorize all medically necessary behavioral health services that may be recommended or ordered pursuant to an EPSDT periodic or inter-periodic screening including medically necessary health care services that are not otherwise covered under the Connecticut Medicaid program. Care managers or other behavioral health ASO staff members are also required to facilitate access to such services when contacted by the recipient or the recipient's designated representative.

# Acute Inpatient Psychiatric Hospitalization for Youth

## Level of Care Guidelines

### Definition

Inpatient treatment services in a licensed general or psychiatric hospital offering a full range of diagnostic, educational, and therapeutic services including arranging for and/or providing psychological testing when medically necessary with capability for emergency implementation of life-saving medical and psychiatric interventions. Services are provided in a physically secured setting. Child/Adolescent admission into this level of care is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. This service is generally used when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization, and intensive brief treatment. This high level of care should be focused on the recovery of each child or adolescent and utilize the resiliency of each child/adolescent by improving current functioning so as to allow for use of community-based alternatives.

### Authorization Process and Time Frame for Service

This level of care requires prior authorization. Admission is based upon a comprehensive risk assessment and mental status exam. The first authorization is dependent upon bypass performance and for non-bypass facilities typically 4 days. Subsequent authorizations are based on the individual needs of the child/adolescent with consideration to the child/adolescent's risk to self, others or disruption in permanency and consideration of the treatment plan and of the physician's recommendations.

Consultations with CT BHP physician will occur in situations where there is a mutually agreed upon possibility of diversion that has a higher likelihood of long-term success or benefit to the child/adolescent, or issues of age or prior effectiveness mitigate hospital benefit.

### Level of Care Guidelines

#### A.1.0 Admission Criteria

A.1.1 Symptoms and functional impairment include all of the following:

A.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention.

A.1.1.2 Symptoms and impairment must be the result of a psychiatric or co-occurring substance abuse disorder,

A.1.2 Presentation consistent with at least one of the following Symptom Categories:

A.1.2.1 Current risk of suicide/self-injury/safety: Imminent risk of suicide or self-injury or an inability to remain safe in a less restrictive environment as manifested by:

A.1.2.1.1 Attempt: Recent and serious suicide attempt indicated by severity of intent with consideration to the child/adolescent's level of impulsiveness, degree of lethality, likely risk such acts will be repeated or significant evidence of inability to assure safety; or

A.1.2.1.2 Intent/Plan: Current suicidal ideation with well formulated plan, imminent intent to act that is severe and dangerous with minimal expressed ambivalence or significant barriers to doing so; or

A.1.2.1.3 Self-mutilation: Recent self-mutilation that is severe and dangerous, e.g., deep cuts requiring sutures, 2<sup>nd</sup> to 3<sup>rd</sup> degree burns, swallowing objects, etc.; or

A.1.2.1.4 An increase in severity or frequency of extreme recklessness, agitation, and/or impulsivity. (E.g. flagrant exposure to victimization, and other potentially highly self-injurious or lethal or risk taking behaviors).

A.1.2.2 Current risk of homicide/danger to others: Imminent risk of homicide or harm to others with inability to remain safe in a less restrictive environment as manifested by: an increase in severity or frequency of extreme recklessness, agitation, and/or impulsivity (e.g. sexual perpetration, criminal assault, playing with knives, death threats) as manifested by:

A.1.2.2.1 Attempt: Recent and serious homicide attempt indicated by severity of intent, impulsivity and/or substance use that is severe and dangerous; or

A.1.2.2.2 Intent/Plan: Current homicidal ideation with well formulated plan, imminent intent to act that is severe and dangerous with minimal expressed ambivalence or significant barriers in doing so; or

- A.1.2.2.3 Severe assault: Recent assaultive behavior (that may include use of a deadly weapon) with a high potential for recurrence and potential for serious injury to self or others.
- A.1.2.3 Psychotic/Hallucinations/Delusions/Paranoia: Acute deterioration in the ability to differentiate between reality and fantasy and/or delusional thinking.
- A.1.2.4 Hallucinations and/or Delusions: Recent auditory commands/tactile/visual hallucinations or delusions that threaten to override usual impulse control and likely result in serious harm to self or others; or
  - A.1.2.4.1 Paranoia and/or Disorganized thinking that substantially compromises the child/adolescent's ability to function and/or likely make safe decisions; or
  - A.1.2.4.2 Responses to delusions, excessive preoccupations, or inability to differentiate fantasy from reality, which substantially interfere with functioning and is likely to result in serious harm to self and/or others (i.e. paranoid ideas that inspire retaliation, delusions of invincibility).
- A.1.2.5 Gravely Disabled: Acute and serious deterioration from baseline in mental status and level of functioning resulting in high risk of harm to self or others. Severe impairment of activities of daily living skills as evidenced by one or more of the following:
  - A.1.2.5.1 Catatonia or Delirium; or
  - A.1.2.5.2 Disorientation to person, place and time or dissociative events which could result in harm to self/others; or
  - A.1.2.5.3 An inability to care for oneself at an age appropriate level.
- A.1.2.6 Acute Medical Risk: Imminent risk for acute medical status deterioration due to the presence and/or treatment of active psychiatric symptom(s) manifested by:
  - A.1.2.6.1 Signs, symptoms, and behaviors that interfere with diagnosis or treatment of a serious medical illness requiring inpatient medical services (e.g., endocrine



disorders such as diabetes and thyroid disease; cardiac conditions; etc.); or

A.1.2.6.2 A need for acute psychiatric interventions (i.e., medications, ECT, restraints) that have a high probability of resulting in serious and acute deterioration of physical and/or medical health; or

A.1.2.6.3 Malnutrition of life-threatening severity and/or highly compromised nutrition or severe eating-disordered beliefs or rituals; immobility; unable to communicate basic needs, etc. Not eating and/or excessive exercise to the point that further weight loss is medically threatening.

A.1.2.7 Medication Adjustment: Child/Adolescent has met any of the above symptoms within the past 12 months and requires a medication taper and re-evaluation in an inpatient hospital setting and that previous attempts to taper medication have resulted in behavioral escalations that meet admission criteria for inpatient hospitalization. These behaviors must be extreme in nature and put the child/adolescent or their family/caregiver at risk of physical or medical injury to require medication changes at inpatient LOC.

**And meets at least one of the following criteria:**

A.1.3 Intensity of Service Need

A.1.3.1 Child/Adolescent requires inpatient psychiatric care with 24-hour medical management. The above symptoms cannot be contained, attenuated, evaluated and treated in a psychiatric residential treatment facility or lower level of care as evidenced by:

A.1.3.1.1 Psychiatric treatment (e.g., medication, ECT) presents a significant risk of serious medical compromise (e.g., ECT for a child/adolescent with a cardiac condition, restraint or seclusion of a child/adolescent with a cardiac condition, initiation of or change in neuroleptic medication for a child/adolescent with history of neuroleptic malignancy syndrome, or administration of Depakote to a child/adolescent with a history of neutropenia); or

A.1.3.1.2 Requires a diagnostic procedure, such as an MRI or 24 hour EEG, which is available in a hospital and

cannot readily be accessed otherwise in a timely fashion. Delay in such procedure would substantially impede the ability to diagnose or enact a treatment plan leading to significant risk or impairment in function; or

A.1.3.1.3 Intrusive route of medication administration requires medical management (e.g., intramuscular (IM) administration of PRN medication or administration by means of an NG tube); or

A.1.3.1.4 The child/adolescent has had frequent (e.g., once every other day) restraints or seclusions or has recently had mechanical restraint; or presented high risk of serious injury to self or others as a consequence of frequency or duration of restraint or seclusion; or

A.1.3.1.5 The child/adolescent requires 1:1 supervision or frequent checks for safety (e.g. every 15 minutes or less) for frequent or prolonged periods; or

A.1.3.1.6 Efforts to manage medical risk symptom or behavior (see III.A.1.b.(4)) in a lower level of care are ineffective or result in acute escalation of behavior with risk of harm to self or others; or

A.1.3.1.7 Requires close medical monitoring or skilled care to adjust dosage of psychotropic medications and such medical monitoring and dosage adjustment could not safely be conducted in a psychiatric residential treatment facility, residential treatment center or ambulatory setting.

A.2.0 **Continued Care Criteria:** A Concurrent Review is individually based and the number of days authorized is based on the quality of the treatment plan and where the child/adolescent is in their recovery. The review will look at how the facility is functioning to get the child/adolescent back to baseline in an expeditious manner while focusing on the resiliency of the child/adolescent.

A.2.1 The child/adolescent has met admission criteria within the past 48 hours or has not exhibited qualifying behavior due to use of 1:1 (or higher) supervision, frequent checks (q5), physical/mechanical restraint, or locked seclusion; and

A.2.1.1 Evidence of active treatment and care management as evidenced by: Child/Adolescent and family/caregiver participation in treatment is consistent with care plan, or active efforts to engage the child/adolescent and/or

family/caregiver are in process. Type, frequency, and intensity of services are consistent with the treatment plan. The provider will initiate contact/communication with family/caregivers within 72 hours of admission; and

A.2.1.2 A care plan and treatment objectives have been clearly defined. Treatment objectives are related to the child/adolescent's reason for admission and contributing factors paying particular attention to their strengths and their family's/caregiver's strengths, with the goal of successful return to a less restrictive setting and enhanced functioning. Interventions including family, educational and community supports required to meet these goals are identified and monitored daily for their effect and altered accordingly; and

A.2.1.3 Vigorous efforts are being made to affect a timely discharge. Any barriers to timely discharge are clearly documented as part of a modified treatment plan daily. Contact with collaterals is sufficiently frequent to then be able to identify and eliminate/reduce any barriers to discharge. CT BHP may offer a Peer Specialist and/or Intensive Care Manager to assist the facility with barriers; and

A.2.1.4 Medication should be reviewed and updated at each concurrent review. The diagnosis should be reviewed and updated at each concurrent review. Family/Caregiver sessions should occur at least 1-2 times per week in order to develop a finalized discharge plan in a timely fashion.

A.2.2 If the child/adolescent does not meet criterion A.2.1 and A.2.2, continued stay may still be authorized under any of the following exceptional circumstances:

A.2.2.1 The child/adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to the community rather than another institutional setting; or

A.2.2.2 The child/adolescent is expected to transfer to another institutional treatment setting and continued stay at this level of care, rather than an interim placement, can avoid disrupting care and compromising patient stability. Continued stays for this purpose may be as long as 30 days; or

A.2.2.3 The child/adolescent is scheduled for discharge, but their community-based aftercare plan is missing critical components. These components have been vigorously pursued but are not available. In addition, community-based services have been explored as an option to transition the

child/adolescent from inpatient to community-based treatment. In such cases, if it is reasonably determined that critical components of the discharge plan will not be available in the near future, the child/adolescent should be discharged to a less restrictive level of care.

**Note:** Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

# Albert J. Solnit Center – Inpatient Psychiatric Hospitalization Level of Care Guidelines

## **Definition**

The services provided at the Albert J. Solnit Center (South) represent the most restrictive inpatient psychiatric hospital level of care within the CT service continuum and are focused on stabilization over a more prolonged period of time or providing specialized treatment services that cannot be provided at acute levels of inpatient care. Treatment is designed to improve functioning such that discharge to a less restrictive setting is both feasible and expected to result in sustained benefit.

Albert J. Solnit Center (South) is the only state-administered psychiatric hospital for Connecticut's children who are ages thirteen to eighteen (13-18). Youth cannot be admitted at the age of 18. Superintendent exceptions can be made for 12 years old on a case by case basis depending on clinical acuity and current milieu. The hospital provides comprehensive care to children and adolescents with severe mental illness and related behavioral and emotional problems who cannot be safely assessed or treated in a less restrictive setting.

The hospital is part of the Department of Children and Families (DCF) treatment continuum.

## **Authorization Process and Time Frame for Service**

This level of care requires prior authorization. Admissions to the Albert J. Solnit Center (South) shall be reviewed for medical necessity and will require concurrent reviews on a periodic basis to facilitate discharge planning.

The facility will demonstrate ongoing efforts in all aspects of treatment and planning to engage and involve the child/adolescent and family/caregivers when appropriate.

If deemed medically necessary, Court ordered admissions to the Albert J. Solnit Center (South) shall be authorized 30 units upon admission. Any court ordered stay beyond 30-days shall require concurrent review and will be authorized for a period of time that is deemed clinically appropriate and medically necessary to address the individualized needs of the child or adolescent.

## **Level of Care Guidelines**

### **B.1.0 Admission Criteria**

B.1.1 To demonstrate the necessity for admission to the Albert J. Solnit Center (South), the child/adolescent must:

B.1.1.1 Meet clinical criteria for acute inpatient care and additionally exhibit behaviors that pose safety concerns of a magnitude (e.g. severe self-mutilation) that cannot be effectively managed or

treated, in other inpatient or outpatient settings,

And meets at least one of the following criteria:

**B.1.2 Intensity of Service Need**

- B.1.2.1 The child/adolescent continues to meet acute care criteria in an inpatient psychiatric setting over an extended period of time and has been non-responsive to aggressive interventions. Level of symptomatology is severe to the extent that the child/adolescent cannot be managed in a Psychiatric Residential Treatment Facility or other less restrictive setting, and/or
- B.1.2.2 The child/adolescent has a severe psychiatric disorder or psychiatric and co-occurring developmental disorder that requires intervention not otherwise available in other inpatient settings, and/or
- B.1.2.3 The child/adolescent has had a recent history of multiple admissions to acute inpatient settings and has demonstrated no appreciable improvement in status as a function of such admissions, and such improvement would be necessary for sustained residence in a less restrictive setting, and/or
- B.1.2.4 The child/adolescent currently resides in a Residential Treatment Center or Group Home and has demonstrated the need for a highly intensive and specialized level of psychiatric care that would not substantially benefit from acute inpatient treatment as demonstrated by a recent history of multiple acute inpatient psychiatric admissions without evident benefit.

**B.1.3 Require specialized evaluation or treatment services not otherwise available in other acute care inpatient settings as evidenced by:**

- B.1.3.1 The child/adolescent requires staffing ratios for safety that can't be provided by an acute inpatient hospital, and/or
- B.1.3.2 The child/adolescent presents symptoms that require specialized diagnostic capability across multiple disciplines not otherwise provided in other acute inpatient facilities, and/or
- B.1.3.3 The child/adolescent requires a sustained period of stabilization over an intermediate length of stay.

**B.2.0 Continued Care Criteria:**

- B.2.1 A Concurrent Review is conducted on each child/adolescent admitted to the Albert J. Solnit Center (South) and is based on each child's/adolescent's individual clinical presentation and needs. The number of days authorized is based on the goals and objectives established in the treatment plan and the child's/adolescent's progress toward those goals. The review will specifically focus on the interventions utilized and the impact of those interventions. Treatment goals must encompass identification of those factors which have prevented and/or are needed to support successful transition to less restrictive levels of care.

- B.2.1.1 The child/adolescent has met admission criteria within the past 7 days or has not exhibited qualifying behavior due to use of 1:1 (or higher) supervision, frequent checks, physical/mechanical restraint, or locked seclusion; and
- B.2.1.2 Length of stay for each of the admissions will be reviewed as well as the reason for the admission, alternative community programs utilized prior to admission, and which of those services proved to be effective; and
- B.2.1.3 A care plan and treatment objectives are developed with the child's/adolescent's and family's/caregiver's participation when appropriate and are clearly defined. Treatment objectives are related to the child/adolescent's capacity to successfully transition to a less restrictive level of care. All efforts are directed toward the child/adolescent's functioning, family/caregiver functioning and readiness for discharge. Progress toward treatment objectives are monitored regularly; and
- B.2.1.4 The child/adolescent's medication management plan and diagnosis will be reviewed as necessary and appropriate at each concurrent review; and
- B.2.1.5 Family sessions (when appropriate) should occur at least 1-2 times per week in order to further treatment objectives and to develop a finalized discharge plan in a timely fashion.
- B.2.1.6 Evidence of active treatment and care management is demonstrated by:
  - B.2.1.6.1 Child/Adolescent and family/caregiver participation in treatment is consistent with the care plan or continued active efforts to engage the child/adolescent and/or family/caregiver are in process. Type, frequency, and intensity of services are consistent with the treatment plan. A family session (when appropriate), must take place within the first week of admission to the facility, and
  - B.2.1.6.2 A care plan with treatment objectives appropriate to an inpatient setting has been clearly defined. Treatment objectives are related to the specific problems that keep the child/adolescent from being able to function successfully in a less restrictive level of care. All efforts are directed toward the child/adolescent's readiness for discharge and progress toward treatment objectives are monitored daily, and
  - B.2.1.6.3 Vigorous efforts are being made to affect a timely discharge. Any barriers to timely discharge are clearly documented as part of a modified treatment plan. Contact



with DCF Area Office staff and/or collateral supports are frequent enough to be able to identify and eliminate/reduce any barriers to discharge. CTBHP may offer a Peer Specialist.

B.2.1.7 If the child/adolescent does not meet criterion B.2.1, continued stay may still be authorized under any of the following exceptional circumstances:

B.2.1.7.1 The child/adolescent can achieve certain treatment objectives in the current level of care in a timely manner and achievement of those objectives will enable the child/adolescent to be discharged directly to the community rather than to another institutional setting; or

B.2.1.7.2 The child/adolescent is expected to transfer to another institutional treatment or foster family setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement, can avoid disrupting care and compromising patient stability. Continued stays for this purpose may be as long as 30 days; or

B.2.1.7.3 The child/adolescent is scheduled for discharge, but their community-based aftercare plan is missing critical components. Discharge Delay status would be identified with the understanding that vigorous and possibly alternative discharge planning occurs.

**Note:** Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise demonstrably limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals that are essential for placement outside of an inpatient setting.

# Psychiatric Residential Treatment Facility

## Level of Care Guidelines

### Definition

Psychiatric residential treatment facility (PRTF) is a community based inpatient facility that provides psychiatric and other therapeutic and clinically informed services to individuals under age 21 according to Federal Medicaid Law. Individual PRTFs may serve varying age ranges dependent upon what is allowable under their licenses. Their immediate treatment needs require a structured 24-hour inpatient residential setting that provides all required services (including schooling) on site while simultaneously preparing the child/adolescent and family for ongoing treatment in the community. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family, and group therapy, parent guidance, substance abuse education/counseling (when indicated) and other support services including on site education. Qualified clinicians are able to meet the cultural, linguistic, ethnic, and recovery needs of all members served within their local community. The level of care is less intensive than acute inpatient hospitalization and more restrictive than residential treatment or home and community-based treatment, including partial hospitalization and home based services. Youth can be admitted directly from the ED, as well as step down from an acute inpatient hospital. On occasion, it may be appropriate for children to be admitted directly from the community as a diversion from acute psychiatric inpatient hospital care.

- a. Upon admission, the child's/adolescent's parent or guardian will be informed of the typical course of treatment and anticipated length of stay, as well as the expectation around their level of involvement including frequency of family sessions, engagement in treatment and planning to support the child's/adolescent's return to their home.
- b. Within the first seven days of admission, a member of the treatment team will draft an initial discharge plan that targets the child's/adolescent's needs. The discharge plan will incorporate the child's/adolescent's identified concerns, including but not limited to: living/family situation, medical care, transportation issues, educational concerns, social supports, crisis prevention plan, list of providers recommended and available to deliver services post-discharge, list of prescribed medications and their dosages and possible side effects, and treatment recommendations consistent with the service plan of the relevant state agency for children or adolescents who are also DCF involved.
- c. The family's natural supports, functional strengths, interests and skills will be explored and incorporated into the discharge plan to ensure that the child's/adolescent's and family's needs are addressed in a comprehensive and strength-based manner. Additionally, the treatment team member will document all efforts related to ensuring a smooth transition home to family when possible and to the next clinical service, including the child's/

adolescent's and family/ guardian's active participation in discharge planning. Aftercare appointments are scheduled within 7 days of discharge. Physician/APRN participation in ongoing team meetings is required. Medication management appointments are held at clinically appropriate frequencies with the child/adolescent and with input from the guardian/family.

- d. Barriers to discharge are identified during the initial authorization timeframe and will be communicated to all other participating providers including but not limited to family, CT BHP, DCF, all current and future community providers, school placement/supporters, and the treating psychiatrist/clinician. If appropriate, a peer support referral can be made.

### **Authorization Process and Time Frame for Service**

This level of care requires prior authorization. Each case will be reviewed on an individual basis. The expected length of stay is between 15 and 30 days for children/adolescents diverted from acute inpatient hospital care, and 30 and 120 days for children/adolescents stepped down from acute inpatient hospital care, depending on clinical and dispositional needs.

### **Level of Care Guidelines**

#### **C.1.0 Admission Criteria**

- C.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention.
- C.1.2 The child/adolescent has recently met acute inpatient psychiatric hospital criteria, but does not meet continued care criteria for the acute inpatient hospital level of care; or
- C.1.3 Child/adolescent has presented in an emergency department and does not meet admission criteria for the acute inpatient hospital level of care; or
- C.1.4 Child/adolescent continues to demonstrate vulnerability to acute exacerbations as evidenced by intermittent acuity in hospital or history of rapid de-compensation with transitions. Discharge to lower level of care would likely lead to the need for hospitalization; or
- C.1.5 Diversion from PRTF (including but not limited to, adding wrap around community supports, respite, one to one support, etc.) level of care has been explored and determined either to not be medically appropriate or unavailable.

## C.1.6 Intensity of Service Need

C.1.6.1 The child/adolescent meets criteria for discharge from a hospital but;

C.1.6.1.1 Key components of a residential or community based treatment plan are unavailable, or

C.1.6.1.2 All less restrictive treatment options have been examined and determined to be ineffective or not immediately available and the individual requires 24-hour supervised care within a psychiatrically staffed residential environment as evidenced by:

- The child's/adolescent's behavior is sufficiently unstable to require immediate professional intervention to protect child/adolescent from harming self and others; or
- The child/adolescent is likely to require intermittent one-to-one supervision, constant observation, or frequent checks for safety; or
- Efforts to manage medical risk, symptoms or behavior in a lower level of care have been examined and determined to be ineffective or result in an acute escalation of behavior with risk of harm to self or others; or
- The child/adolescent requires close medical monitoring or skilled care to evaluate and adjust dosage of psychotropic medications and such medical management and dosage adjustment could not safely be conducted in a residential treatment center, or ambulatory setting; or
- The child/adolescent requires a medication taper and re-evaluation in a closely monitored setting. Previous attempts to taper medication have resulted in behavioral escalations that meet admission criteria for inpatient hospitalization.

## C.2.0 Continued Care Criteria

C.2.1 The child/adolescent has met level of care criteria within the last seven days; and

C.2.2 There is evidence of active treatment and care management as evidenced by:

C.2.2.1 There is family/caregiver and child/adolescent participation in treatment planning and it is consistent with the care

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and, for anyone under 21, does not meet the EPSDT criteria.

plan, or active efforts to engage the family/caregiver and child/adolescent are in process. Type, frequency, and intensity of services are consistent with the treatment plan, and

- C.2.2.2 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. The care plan includes an updated working diagnosis. Treatment objectives are related to readiness for discharge and progress toward objectives is being made and monitored daily.
- C.2.2.3. Vigorous efforts are being made to affect a timely discharge. Any barriers to timely discharge are clearly documented as part of a modified treatment plan. Contact with collateral supports are frequent enough to be able to identify and eliminate/reduce any barriers to discharge.
- C.2.3 If the child/adolescent does not meet criterion C.2.1 continued stay may still be authorized under any of the following exceptional circumstances:
  - C.2.3.1 The child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved within their anticipated length of stay and are determined necessary in order for the discharge plan to be successful, and there is another suitable environment in which the objectives can be safely accomplished.
  - C.2.3.2 The child/adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the individual to be discharged directly to the community rather than to another congregate care setting. Continued stays for this purpose will be determined on an individual basis by the Care Manager.
  - C.2.3.3 The child/adolescent is expected to transfer to another institutional setting within thirty days of discharge and continued stay at this level of care, rather than interim placement, can avoid disrupting care and compromising stability. Continued stays for this purpose will be determined on an individual basis by the Care Manager.
  - C.2.3.4 The child/adolescent is scheduled for discharge, but his/her community-based aftercare plan is missing critical components. These components have been vigorously pursued but are not available (including but not limited to resources such as placement options, psychiatrist or therapist appointments, day

treatment, partial hospital programs, and therapeutic school placements. Under such circumstances, the Care Manager or Intensive Care Manager will work closely with the DCF Area Office if the child is DCF involved or directly with the local providers or Community Collaboratives and family/caregiver to address aftercare needs.

**Note:**

In any of the above C.2.3 circumstances, a case conference will be held with all providers, CT BHP, DCF, family, etc.

**Making of Level of Care Decisions**

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

# Residential Treatment Center – Youth Level of Care Guidelines

## Definition

A Residential Treatment Center (RTC) is a 24 hour facility licensed as such by the State of Connecticut or appropriately licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living within the parameters of clinically informed milieu and based on a well-defined, individually tailored treatment plan. This level of care is reserved for those children/adolescents whose psychiatric and behavioral status warrants the structure and supervision afforded by a self-contained setting that has the ability to offer all necessary services including an on-site educational program, and provide line of sight supervision *when necessary*. Clinical consultation is available at all times and physical restraint may be used in emergency situations, as necessary to prevent immediate or imminent injury to the client or others. RTC can serve as a step down from psychiatric hospitalization or may serve as the treatment of choice when a child's behavioral status places them or the community at risk should services be offered in a less restrictive setting.

## Authorization Process and time Frame for Services

This level of care requires prior authorization. Each youth considered for this level of care must have a Child and Adolescent Needs and Strengths (CANS) Comprehensive Multi-system Assessment and any additional diagnostic service (e.g., face-to-face interview, psychological testing, medication evaluation, family interview) necessary to develop a complete clinical and psychosocial profile of the youth's service needs. The CANS will support the development of a treatment plan that will identify any individual service needs that require implementation within the Residential Treatment Center or through supplemental community-based clinical services.

## Level of Care Guidelines

### D.1.0 Admission Criteria

D.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention.

D.1.2 Chronic (>6-months) presentation of the following behaviors consistent with at least one of the following:

D.1.2.1 Recurrent suicidal gestures and/or attempts with significant risk of self-injury; or

D.1.2.2 Recurrent self-mutilation that requires non-urgent medical intervention and that presents some potential

for danger, e.g., through infection; or

D.1.2.3 Recurrent deliberate attempts to inflict serious injury on another person; or

D.1.2.4 Unremitting reckless behavior suggesting an unwillingness to consider potential for risk to self or others (e.g. fire setting, psychosexual behavior problems; reckless driving; and other risk-taking behavior); or

D.1.2.5 Unremitting impulsive, defiant, antagonistic or provocative behavior with potential for risk to self or others; or

D.1.2.6 Recurrent agitated and uncontrolled behavior including acts of violence against property or persons; or

D.1.2.7 Recurrent dangerous or destructive behavior; or

D.1.2.8 Recurrent psychotic symptoms/behavior that pose a significant risk to the safety of the child/adolescent or others, or markedly impaired functioning in one or more domains; or

D.1.2.9 Recurrent and marked mood lability resulting in severe functional impairment; or

D.1.2.10 Recurrent intimidation/threats of aggression with moderate to high likelihood that they will be acted upon and result in serious risk to others.

## D.2.0 Intensity of Service Need

D.2.1 Child/Adolescent requires residential treatment without 24-hour medical monitoring as evidenced by either:

D.2.1.1 The above symptoms cannot be contained, attenuated, evaluated and treated in a home type living situation with any combination of outpatient and intensive ambulatory services due to:

D.2.1.1.1 Child/Adolescent presents moderate risk for requiring restraint/seclusion as evidenced by the use of such during the 3-month period immediately preceding admission. Restraints were occasional (not more than once every two weeks), could be administered with fewer than 3



persons and did not present high risk of serious injury to self or others. Seclusions were not locked; or

D.2.1.1.2 Child/Adolescent requires 24-hour awake supervision in order to safely manage behaviors in above or due to high AWOL risk, or

D.2.1.2 Documented efforts to provide intensive community-based treatment (e.g., , extended day treatment/intensive outpatient treatment, home-based services, intensive intervention within the school environment) while the child/adolescent is living in a home type setting. (e.g., *birth, relative, adoptive, foster, therapeutic foster, or group home*) have been implemented within the past six months and have not resulted in safe, manageable behavior in the home setting; or

D.2.1.3 Necessary, less restrictive intensive community-based services needed to support the child/adolescent in a home setting are not currently available and clinical issues require this level of care as an appropriate alternative.

### D.3.0 Continued Stay Criteria

#### D.3.1 Severity of Illness

D.3.1.1 Symptoms and impairment must be a result of a psychiatric or substance abuse disorder, and

D.3.1.2 Clinical or treatment circumstances consistent with one of the following:

D.3.1.2.1 Child/Adolescent has exhibited behavior consistent with admission criteria within the past 6 weeks; or

D.3.1.2.2 Child/Adolescent has been prevented from engaging in above qualifying behavior due to use of 1:1 supervision, frequent checks (q15), physical/mechanical restraint or locked seclusion; or

D.3.1.2.3 Child/Adolescent's history, current presentation, and treatment progress strongly suggest that discharge to a lower level of care presents a high likelihood of deterioration in the patient's condition, high-risk behavior, and the inability to continue to make progress on treatment goals. This might be evidenced by recent (e.g., past 8

weeks) history of failed attempts to transition from this level and type of care with adequate aftercare supports or deterioration in behavioral functioning during a recent period without this level of care, e.g., during holiday or day/multi-day passes

D.3.2 If the child/adolescent does not meet the above criteria, continued treatment may still be authorized under the following circumstances:

D.3.2.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved within 30 days and are determined necessary in order for the discharge plan to be successful, and there is no less restrictive environment in which the objectives can be safely accomplished; or

D.3.2.1.1 Child/adolescent can achieve certain treatment objectives including appropriate pharmacological treatment, in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to the community rather than to another restrictive setting; or

D.3.2.1.2 Child/adolescent is expected to transfer to another residential setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement can avoid disrupting care and compromising the stability of the child/adolescent. Continued stays for this purpose may be as long as 30 days; or

D.3.2.1.3 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, therapeutic mentoring, etc.). Referral to the child's DCF Area Office for review is indicated.

**Note:** Making of Level of Care Decisions

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care

requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

# Therapeutic Group Home – Youth

## LEVEL II

### Level of Care Guidelines

#### Definition

A Level II Therapeutic Group Home (TGH) is a small, four- to- six bed, DCF or DDS licensed program located in a neighborhood setting with intensive staffing level and services offered within the context of a 24/7 home-like milieu. It is a highly structured treatment program that creates a physically, emotionally and psychologically safe environment for children and adolescents with complex behavioral health needs who need additional support and clinical intervention to succeed in either a family/caregiver environment or in an independent living situation. Education is provided off site through the local education authority. Community based activities (recreational, vocational, social development) serve as a focus for clinical and rehabilitative intervention. As such, the Level II TGH is designed to develop and promote optimal functioning within the context of a normative environment utilizing highly specific individualized treatment. A Level II TGH is *not* to be used solely for the purpose of housing/care/custody or as an alternative to incarceration.

#### Authorization Process and Time Frame for Services

This level of care requires prior authorization. Each youth considered for this level of care must have a Child and Adolescent Needs and Strengths (CANS) Comprehensive Multi-system Assessment and any additional diagnostic service (e.g., face-to-face interview, psychological testing, medication evaluation, family interview) necessary to develop a complete clinical and psychosocial profile of the youth's service needs. The CANS will support the development of a treatment plan that will identify any individual service needs that require implementation within the Therapeutic Group Home or through supplemental community-based clinical services.

#### Level of Care Guidelines

##### E.1.0 Admission Criteria

E.1.1 Symptoms and Functional Impairment include:

- E.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention. Symptoms are primarily the result of a psychiatric disorder, or Intellectual Disability. Substance Abuse may be co-occurring,
- E.1.1.2 Child /Adolescent requires 24 hour structured therapeutic milieu due to chronic (greater than 6 month) presentation of at least *one* of the following behaviors:

- E.1.1.2.1 Past history of suicidal and/or homicidal thoughts and/or impulses with significant current ideation without intent or conscious plan; or
- E.1.1.2.2 Frequent and severe verbal or physical aggression directed toward self and others that interferes with development of successful interpersonal relationships; or
- E.1.1.2.3 Episodic impulsivity and/or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g., status offenses, AWOL, self-injurious behavior, fire setting, violence toward animals) or
- E.1.1.2.4 Recurrent psychotic symptoms/behavior that pose a significant risk to the safety of the child/adolescent or others, or markedly impaired functioning in one or more domains

E.1.1.3 And one of the following conditions:

- E.1.1.3.1 Moderate to severe functional problems in school/vocational setting or other community setting (e.g., school suspension, involvement with the law) due to inability to accept age appropriate direction or supervision from family/caregivers; or
- E.1.1.3.2 Chronic medical condition that requires assistance to achieve compliance with prescribed medical regimen (e.g., diabetes treatment, asthma treatment); or
- E.1.1.3.3 Demonstrated inability to form trusting relationships with family/caregivers (including regular and specialized foster care) that prohibit success in a family/caregiver setting; or
- E.1.1.3.4 Demonstrated inability to tolerate a large congregate care setting (e.g., larger than six beds)

E.1.2 Intensity of Service Need

- E.1.2.1 The child/adolescent cannot be treated in a *family/caregiver* setting with a combination of outpatient and intensive ambulatory services due to demonstrated low tolerance for family/caregiver environment or marked

intolerance for adult authority as evidenced by one of the following:

- E.1.2.1.1 Two or more failures in home or foster home settings with intensive community-based services and supports due to disruptive behavior that has placed child, caregivers or other members of the household at risk for injury to person or property; or
- E.1.2.1.2 Qualitative impairment in social interaction, lack of social/emotional reciprocity, failure to develop peer relations appropriate to developmental level and/or a profound mistrust of others due to previous trauma or pervasive developmental disorder, and
- E.1.2.1.3 Child/Adolescent requires specialized and intensive clinical and rehabilitative intervention provided by trained staff to achieve optimal control over emotions and to exhibit behavior appropriate to age and community expectations or
- E.1.2.1.4 Child/Adolescent is vulnerable to crisis and may require access to on-site 24-hour emergency evaluation and crisis intervention and
- E.1.2.1.5 Child/Adolescent is able to attend off site educational placement

## E.2.0 Continued Care Criteria

### E.2.1 Severity of Illness

- E.2.1.1 Symptoms and impairment must be the result of a psychiatric or substance use disorder or intellectual disability, and
- E.2.1.2 Clinical or treatment circumstances consistent with one of the following:
  - E.2.1.2.1 Child/Adolescent has exhibited behavior consistent with admission criteria within the past 60 days; or
  - E.2.1.2.2 Child/Adolescent has been hospitalized for symptoms that preclude a lower level of care within the past 30 days; or

E.2.1.2.3 Child/Adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals, and

E.2.1.3 There is evidence of active treatment and care management as evidenced by:

E.2.1.3.1 A care plan has been established with treatment objectives appropriate for this level of care. Treatment objectives are related to improved behavioral and social/emotional functioning, and are tied to the child's long-range permanency plan (e.g., return to home, discharge to foster care, independent living, or alternative treatment setting within the adult system). Progress toward objectives is being monitored at a level appropriate to child's permanency needs, and

E.2.1.3.2 Child's participation in treatment is consistent with care plan or active efforts to engage child are in process. Type, frequency and intensity of services are consistent with treatment plan, and

E.2.1.3.3 Vigorous efforts are being made to affect a timely discharge to the next level of care (e.g., lower level group home, transitional living program, independent living, foster family, biological family) including, but not limited to case conferences and appointments with aftercare providers, clinical interventions with future caregivers, educational/vocational planning as indicated.

E.2.1.4 If the child/adolescent does not meet above criteria, continued stay may still be authorized under the following circumstances:

E.2.1.4.1 Child/Adolescent has clear, behaviorally defined treatment objectives that can reasonably be achieved within 30 days and are determined necessary in order for the discharge plan to be successful, and there is no less restrictive environment in which the objectives can be safely accomplished; or

E.2.1.4.2 Child/Adolescent can achieve certain treatment

objectives in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged to a less restrictive community-based setting; or

E.2.1.4.3 Child/Adolescent is expected to transfer to a less restrictive community-based setting within 30 days of discharge and continued stay at this level of care, rather than an interim placement can avoid disrupting care. Continued stays for this purpose may be as long as 30 days; or

E.2.1.4.4 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to therapist appointments, therapeutic mentoring, etc.) Referral to the child's DCF Area Office for review is indicated; or

E.2.1.4.5 Child/Adolescent has been approved for long term placement in the Therapeutic Group Home as part of the DCF Permanency Plan which has been approved by the DCF Area Office.

**Note:** Making of Level of Care Decisions

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.



# **Intermediate Care Level of Care Guidelines**

## **Definition**

Intermediate care refers to a continuum of ambulatory psychiatric treatment programs that offer intensive, coordinated and structured therapeutic and assessment services within a stable therapeutic milieu. These programs encompass partial hospital (PHP), intensive outpatient (IOP) and extended day treatment (EDT) levels of care. All programs require psychiatric evaluation, treatment planning and oversight and serve as a step down to, or diversion from, inpatient levels of psychiatric care. Multiple treatment modalities (i.e., individual therapy, group therapy, family therapy, medication management, therapeutic recreation) are integrated within a single treatment plan that focuses on child/adolescent specific goals and objectives. Services are office based although some programs may allow for structured off -site activity. Programs vary according to intensity of service (day/hours offered weekly) and length of stay.

## **Authorization Process and Time Frame for Service**

This level of care requires prior authorization. Timeframe for initial authorization vary according to authorization guidelines for the level of care for which admission is requested. Generally, PHP and IOP provide more intensive service over a brief period of time to stabilize a child's/adolescent's functioning, while EDT offers clinical intervention and rehabilitative services over a longer period of time to help the child/adolescent achieve success in a less restrictive setting that incorporates community-based activities into the treatment plan. Some IOP level services are specialized in clinical focus or treatment model and are operated as intensive service components of outpatient clinics.

## **Use of Guidelines**

The following guidelines are to be used when determining access to any of these three levels of Intermediate Care. Differences in admission, intensity of service need, and continued care for each of these three services are addressed in the service grid to be used conjointly with these guidelines.

## **Level of Care Guidelines**

### **G.1.0 Admission Criteria**

G.1.1 Symptoms and functional impairment include all of the following:

- G.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD,
- G.1.1.2 Symptoms and impairment must be the result of a primary psychiatric disorder, and substance use disorders may be secondary,
- G.1.1.3 Functional impairment not solely a result of Autism Spectrum Disorder or Intellectual Disability, and

G.1.1.4 Acute onset or exacerbation of an illness or persistent presentation (e.g., over a 6 month period) of at least one of the following

**Symptom Categories:**

G.1.1.4.1 Suicidal gestures or attempts or suicidal ideation or threats that are serious enough to lead to suicidal attempts; or

G.1.1.4.2 Self-mutilation that is moderate to severe and dangerous; or

G.1.1.4.3 Deliberate attempts to inflict serious injury on another person; or

G.1.1.4.4 Dangerous or destructive behavior as evidenced by episodes of impulsive or physically or sexually aggressive behavior that present a moderate risk; or

G.1.1.4.5 Psychotic symptoms or behavior that poses a moderate risk to the safety of the child or others; or

G.1.1.4.6 Marked mood lability as evidenced by frequent or abrupt mood changes accompanied by verbal or physical outbursts/aggression; or

G.1.1.4.7 Marked depression or anxiety as evidenced by significant disruption of activities of daily living or relationships with families/caregivers and peers; or

G.1.1.4.8 Acute eating disorder symptoms that are moderate to severe and compromise daily functioning (e.g. severe eating disordered beliefs, food restriction, excessive exercise, recurrent binge eating and/or purging); or

G.1.1.4.9 Marked trauma or acute stress related symptoms (e.g. nightmares, flashbacks, hypervigilance, dissociation) resulting in significant impairment in daily functioning.

**And meets at least one of the following criteria:**

**G.1.2 Intensity of Service Need**

G.1.2.1 The child/adolescent requires an organized, structured program up to 5 days per week. The intensity of service and the length of stay vary according to the child's/adolescent's needs and the program type. The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:

G.1.2.1.1 One or more recent efforts to provide or enhance outpatient treatment have been unsuccessful; or

- G.1.2.1.2 Recent attempts to engage the child/adolescent and/or family/caregivers in outpatient therapy have been unsuccessful or the child/adolescent and family/caregivers have been noncompliant with treatment; or
- G.1.2.1.3 The child/adolescent is acutely symptomatic and needs to be stepped down or diverted from inpatient level of care. Child/adolescent remains moderately to severely symptomatic and there is a high likelihood that the child/adolescent's condition would deteriorate if treated in a lower level of care.

### **Program Specific Requirements:**

**PHP:** Child/adolescent demonstrates severe and disabling level of symptomatology that severely impairs the child/adolescent's capacity to function adequately in multiple areas of life on a day-to-day basis. It is highly likely that the child/adolescent will require an inpatient level of care or will quickly deteriorate to a level of functioning that would require an inpatient admission without the intensive daily services of the PHP level of care. The child/adolescent requires at least 4 hours/day of structured programming five days a week for a brief period of time with at least 3.5 hours of documented clinical service. May need continued diagnostic work and medication evaluation. May have been unsuccessful in IOP or other day program.

**IOP:** Child/adolescent demonstrates moderate level of symptomatology that has a moderate impact on the child/adolescent's capacity to function adequately in multiple areas of life on a day-to-day basis. The child/adolescent is at substantial risk for further decompensation, deterioration or self-harm and inpatient hospitalization without IOP services. Child/adolescent requires at least 3 hours/day of structured programming for 2-5 days per week for a brief period of time with at least 2.5 hours of documented clinical service. Some specialized IOP programs may require longer lengths of stay. Requires little or no additional diagnostic work but may require medication management. Has been unsuccessful in outpatient or other community-based programs.

**EDT:** Child/adolescent demonstrates moderate level of symptomatology that appears to be persistent in nature (i.e., greater than six months) although may be the result of an acute exacerbation of symptoms and lack of success in shorter term intermediate programs, intensive home-based programs or other community-based services. This program must be 3 or more hours in duration 2-5 days per week with at least 2.5 hours of documented therapeutic services which includes rehabilitative therapies (i.e. activities that restore social skills, age appropriate activities of daily living) and clinical therapies such as individual, group and/or family therapy.

## G.2.0 Continued Care Criteria

- G.2.1 Child/Adolescent has met admission criteria within the past three (3) days for PHP, five (5) days for IOP, and thirty (30) days for EDT evidenced by:
  - G.2.1.1 The child's/adolescent's symptoms or behaviors persist at a level of severity documented at the most recent start for this episode of care; or
  - G.2.1.2 The child/adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals, and
- G.2.2 Evidence of active treatment and care management as evidenced by:
  - G.2.2.1 A care plan has been established with evaluation and treatment objectives appropriate for this level of care. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and
  - G.2.2.2 Child/Adolescent and family/caregiver participation in treatment is consistent with care plan or active efforts to engage the child/adolescent and family/caregiver are in process. Type, frequency and intensity of services are consistent with treatment plan, and
  - G.2.2.3 Vigorous efforts are being made to affect a timely discharge (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments).
- G.2.3 If child/adolescent does not meet above criteria, continued stay may still be authorized under any of the following circumstances:
  - G.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved within 5 days for PHP, 10 days for IOP and 30 days for EDT, and are determined necessary in order for the discharge plan to be successful, and there is not suitable lower level of care in which the objectives can be safely accomplished; or
  - G.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to the community rather than to a more restrictive setting; or
  - G.2.3.3 Child/adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, day treatment or intensive outpatient treatment etc.) Authorization may be extended in increments for up to 5 days for PHP, 10 days for IOP and up to 30 days for EDT. Under

such circumstances, the Intensive Care Manager will work closely with the DCF Area Office if the child is DCF involved or directly with local providers or Community Collaboratives to address aftercare needs.

**Note:** Making of Level of Care Decisions

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

**Intermediate Levels of Care -  
Partial Hospital, Intensive Outpatient, Extended Day Treatment**

| <b>Aspects of Care</b>                        | <b>Partial Hospitalization</b>  | <b>Intensive Outpatient</b>   | <b>Extended Day Treatment</b>  |
|---|---|---|--|
| <b>Hours Per Day</b>                          | At least 4 Hours Per Day  | At least 3 Hours Per Day  | At least 3 Hours Per Day   |
| <b>Days Per Week</b>                          | 5 Days per week   | 2-5 Days per week   | 2-5 Days per week  |
| <b>Documented Clinical Activities</b>         | 3.5 hours of documented clinical service  | 2.5 hours of documented clinical service.   | 2.5 hours of documented therapeutic services such as rehabilitative services (i.e. activities that restore social skills, age appropriate activities of daily living) and clinical services (individual, group and family therapy)                       |
| <b>Medical Oversight</b>                      | Participants are under the care of a physician who directs treatment. Client may require intensive nursing and/or medical intervention  | Participants are under the care of a physician who directs treatment. Client may require medical monitoring, adjustments and observation of side effects by medically trained staff.  | Participants are under the care of a physician who directs treatment. Client may require medical monitoring, adjustment and observations of side effects by medically trained staff.   |
| <b>Community Based Therapeutic Recreation</b> | Rehabilitative therapies (i.e, activities that restore social skills, age-appropriate activities of daily living) may be incorporated into the milieu. Services are provided on-site, the goals are short-term.                           | Rehabilitative therapies (i.e., activities that restore social skills, age appropriate activities of daily living) may be incorporated into the milieu. Services are provided on-site, the goals are short-term.                          | Rehabilitative therapies (i.e., activities that restore social skills, age appropriate activities of daily living) are a major focus of the program and occur onsite and offsite with the primary goal of reintegration into community-based activities. |
| <b>Therapy</b>                                | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family therapy provided at least 1x weekly unless contraindicated. | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family therapy provided at least 1x weekly unless contraindicated. | Individual, group and/or rehabilitative therapies (i.e., activities that restore social skills, age-appropriate activities of daily living) provided on a daily basis. Family involvement in treatment is expected.                                      |
| <b>Target Length of Stay</b>                  | 2-4 weeks   | 2-6 weeks   | Up to 6 months   |
| <b>Clinical Intensity</b>                     | Child/adolescent demonstrates severe level of symptomatology requiring 4-6 hours/day of structured programming five days a week for brief period of time. May need continued diagnostic work and medication evaluation.                   | Child/adolescent demonstrates moderate level of symptomatology requiring at least 3 hours/day of structured programming for 2-5 days per week for a brief period of time. Requires little or no diagnostic work but may                   | Child/adolescent demonstrates moderate level of symptomatology that appears to be persistent in nature (i.e., greater than six months) requiring at least 3 hours/day of structured programming.   |

|  |   |   |   |
|--|---|---|---|
|  | <p>May have been unsuccessful in IOP or other day program or may have recently been released from inpatient level of care or may have recently been unsuccessful in outpatient level of care.</p> | <p>require medication management. Has been unsuccessful in outpatient or other community-based programs or is stepping down from PHP or inpatient level of care and meets admission criteria for IOP level of care.</p> | <p>Child/Adolescent may also demonstrate lack of success in shorter term intermediate programs or other community-based programs.</p> |
|--|---|---|---|

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and, for anyone under 21, does not meet the EPSDT criteria.

# INTENSIVE IN HOME CHILD AND ADOLESCENT PSYCHIATRIC SERVICES

## Definition

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) is a manualized treatment model designed to prevent children and adolescents from psychiatric hospitalization or institutionalization or to support discharge from inpatient levels of care. While children/adolescents with psychiatric symptoms are the focus of intervention, the model addresses and intervenes with the domains that impact the child/adolescent most directly: family/caregiver, school, community resources and service systems.

IICAPS is an intensive, home-based service designed to address specific psychiatric disorders in the identified child/adolescent, while remediating problematic parenting practices and/or addressing other family/caregiver challenges that effect the child/adolescent and family's/caregiver's ability to function. Efforts are also made within the service to improve the child's/adolescent's educational programming and to ameliorate any environmental factors that may contribute to the child's/adolescent's psychosocial adversity. IICAPS teams typically spend five hours per week working directly with children/adolescents and their families/caregivers and managing their care. Some flexibility in the number of hours of service per week is permitted but typically, for most weeks of service, no fewer than 4, or no more than 6 hours of direct care are provided. Children/Adolescents receiving IICAPS services are likely to be recipients of concurrent services from other mental health providers. IICAPS teams will work in collaboration with these providers during the IICAPS intervention as these providers' involvement with the child/adolescent and family/caregiver often extends beyond the IICAPS Episode of Care.

## Authorization Process and Time Frame for Service

This level of care requires prior authorization or may be web registered. IICAPS can only be provided by a treatment provider who is approved by the Department of Children and Families as an IICAPS provider.

The Initial authorization period is typically within a 60 to 120 days range based on the clinical needs of the child/adolescent and family/caregiver. Typically the service is 1 to 3 contacts per week, for five hours of direct service to children/adolescents and families/caregivers. Direct service hours may be adjusted based on clinical needs of the child/adolescent and family/caregiver and additional contact per week may be authorized, but typically direct service ranges between 4-6 hours per week. The IICAPS Intervention is typically six months long but may be extended with special review.

## Level of Care Guidelines

### **H.1.0 Admission Criteria**

H.1.1 Symptoms and functional impairment include all of the following:



- H.1.1.1 Diagnosable disorder, according to the most recent DSM, which requires and can be reasonably expected to respond to therapeutic intervention.
- H.1.1.2 Symptoms and impairment must be the result of a primary psychiatric disorder; substance use disorders may be secondary.
- H.1.1.3 Functional impairment not solely a result of Autism Spectrum Disorder or Intellectual Disability,

H.1.2 Presentation consistent with at least one of the following:

- H.1.2.1 Recent and/or ongoing risk of deliberate attempts to inflict serious injury to self; or
- H.1.2.2 Recent and /or ongoing self-mutilation that is severe and dangerous; or
- H.1.2.3 Recent and/or ongoing risk of deliberate attempts to inflict serious injury on another person; or
- H.1.2.4 Recent and/or ongoing dangerous or destructive behavior as evidenced by indication of episodic impulsivity or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g., impulsive acts while intoxicated, self mutilation, running away from home or placement with voluntary return, fire setting, violence toward animals, affiliation with dangerous peer groups); or
- H.1.2.5 Recent and/or ongoing psychotic symptoms or behavior that poses a moderate risk to the safety of the child/adolescent or others (e.g., hallucination, marked impairment of judgment); or
- H.1.2.6 Recent and/or ongoing marked mood lability as evidenced by frequent or abrupt mood changes accompanied by verbal or physical outbursts/aggression and/or destructive behaviors or marked depression, anxiety, or withdrawal from activities and relationships and peers

H.1.3 Children/Adolescents appropriate for IICAPS services are those for whom:

- H.1.3.1 There is a family/caregiver resource that is available, willing and able to participate in this intensive home-based intervention
- H.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety
- H.1.3.3 It is possible to willingly enter into a reliable contract for safety (applicable only when a developmentally appropriate expectation)

#### H.1.4 Intensity of Service Need

- H.1.4.1 The child's/adolescent's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves family members/caregivers as primary intervention specialists, and/or
- H.1.4.2 The child/adolescent has been admitted to, or is at risk of being admitted to a psychiatric inpatient unit or is being discharged from a residential treatment center and demonstrated the above admission criteria prior to placement.
- H.1.4.3 The child/adolescent is either in out of home care and requires intensive in-home care as part of the individual care plan or is at high risk for out of home care.
- H.1.4.4 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:
  - H.1.4.4.1 Recent attempts to engage the child/adolescent and/or family/caregivers in therapy have been unsuccessful; or
  - H.1.4.4.2 The above problems occur in context of a regular and significant outpatient therapeutic relationship despite efforts to augment such treatment (e.g., medication consultation or increased outpatient therapy visits or addition of family/caregiver therapy, psychological assessment, group therapy, etc).

#### **H.2.0 Continued Care Criteria**

H.2.1 Child/Adolescent has met admission criteria within the past thirty (30) days for IICAPS as evidenced by:

H.2.1.1 The child/adolescent's symptoms or behaviors persist at a level of severity documented at the start of this episode of care; or

H.2.1.2 The child/adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or

H.2.2 Evidence of active treatment and care management as evidenced by:

H.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and

H.2.2.2 Child/adolescent and family/caregiver participation in treatment is consistent with care plan, or active efforts to engage the child/adolescent and/or family/caregivers are in process. Type, frequency and intensity of services are consistent with treatment plan, and

H.2.2.3 Efforts are being made to affect a timely transition to outpatient care (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments).

H.2.2.4 Children/Adolescents receiving IICAPS services can receive concurrent treatment from other mental health providers including but not limited to out-patient, extended day, and partial hospital services if deemed appropriate in the treatment plan.

H.2.3 If child/adolescent does not meet criterion E.3.1, continued treatment may still be authorized under any of the following circumstances:

H.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through continued home based treatment and such treatment is necessary in order for the discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or

H.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to a less intensive community rather than to a more restrictive setting; or

H.2.3.3 Child/adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, therapeutic mentoring, etc). Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with the DCF Area Office or directly with local providers or Community Collaboratives to address aftercare needs).

**Note:** Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

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# Multidimensional Family Therapy

## Level of Care Guidelines

### **Definition**

Multidimensional Family Therapy (MDFT) is a family-focused, ecologically oriented evidence-based model effective in the treatment of children/adolescents between the ages of 9 – 18 with substance use disorder, or children/adolescents with disruptive behavior and/or co-morbid psychiatric issues who are at risk for substance use. MDFT is designed to reduce the influence of factors that place a child/ adolescent at risk for substance use while strengthening the presence of protective factors, such as supporting a positive parent/caregiver-child relationship.

MDFT was developed by Dr. Howard Liddle, from the University of Miami, and targets several facets in a child/adolescent's life in order to alleviate the presenting problems of substance use or high risk behaviors and co-morbid psychiatric issues. The approach combines clinical intervention with case management type activity and assumes change to be multi-determined. MDFT will work with parents/caregivers and children/adolescents to facilitate compliance with any prescribed medications and psychiatric medication.

Interventions are multidimensional and include the child/adolescent and/or the parent/caregiver, family members, and representatives from systems external to the family (e.g., education, juvenile justice, peers, social services). It is expected that interventions are inclusive of all family/caregiver and environmental influences that affect the individual child or adolescent's success within treatment.

### **Authorization Process and Time Frame for Service**

This level of care requires pre-authorization and can only be provided by a treatment provider who is participating in the credentialing process through MDFT International, Inc. (or their designee) and approved by the Department of Children and Families as an MDFT provider. In addition, on-going participation in the MDFT consultation and training from the state based MDFT certification center is required for all MDFT providers. The number of sessions will be dictated by the needs of the child/adolescent and family/caregiver, but is not to be less than one to three contacts (60-90 minutes/contact) per week, or 210 units (15 minutes per unit) for two months with two concurrent reviews. Typically, services can last from four to six months. If needed drug screens are conducted on a routine basis, but results are not shared externally.

### **Level of Care Guidelines**

#### **I.1.0 Admission Criteria**

I.1.1 Symptoms and functional impairment include all of the following:

- I.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention,

- I.1.1.2 Symptoms and impairment must be the result of primary substance use or the child/adolescent must be at risk of substance use with co-occurring disruptive behaviors. Other psychiatric issues can be present,
  - I.1.1.3 Functional impairment not solely a result of Autism Spectrum Disorder or Intellectual Disability,  
and
  - I.1.1.4 IQ > 60
- I.1.2 Presentation consistent with substance use or risk of substance use and at least one of the following:
- I.1.2.1 Recent and /or ongoing emotional and/or behavioral problems that are severe and potentially dangerous; or
  - I.1.2.2 Recent and/or ongoing involvement with legal system (status offenses, impulsive acts, running away from home) or
  - I.1.2.3 Recent and/or ongoing behaviors that pose a moderate risk to the safety of the child/adolescent or others (e.g., depression marked impairment of judgment); or
  - I.1.2.4 Withdrawal from activities and relationships with peers and family member/caregivers.
- I.1.3 Children/Adolescents appropriate for MDFT services are those for whom
- I.1.3.1 A family/caregiver resource is available to participate in the treatment program, and
  - I.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety, and
  - I.1.3.3 A crisis plan has been developed.
- I.1.4 Children/Adolescents for whom MDFT is **not** medically appropriate, are those children/adolescents who currently demonstrate any of the following:
- I.1.4.1 Child/Adolescent is actively suicidal (ideation and plan); or
  - I.1.4.2 Child/Adolescent currently exhibits a psychotic disorder (or

- features); or
- I.1.4.3 Primary presenting problem is an eating disorder; or
- I.1.4.4 Child/Adolescent engages in fire setting activity; or
- I.1.4.5 The child's/adolescent's problems in functioning are primarily a function of current abusive and neglectful home environment; or
- I.1.4.6 The family's/caregiver's primary need is for respite, social support and/or social welfare service.

**I.1.5 Intensity of Service Need**

- I.1.5.1 The child/adolescent has been admitted to, or is at risk of being admitted to a residential treatment program, or detention facility; or
- I.1.5.2 The child/adolescent has had frequent (i.e., four times within a 6 month period) visits to an emergency room setting due to disruptive behavior; and
- I.1.5.3 The child's/adolescent's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves family members/caregivers, school, peers, other systems as primary intervention specialists, and
- I.1.5.4 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community based care as evidenced by one of the following:
  - I.1.5.4.1 Recent attempts to engage the child/adolescent and/or family/caregiver in outpatient therapy have been unsuccessful; or
  - I.1.5.4.2 The above problems occur in context of a regular and significant outpatient therapeutic relationship despite efforts to augment such treatment (e.g., medication consultation or increased outpatient therapy visits or addition of family/caregiver therapy, psychological assessment, group therapy, etc) or
  - I.1.5.4.3 The child/adolescent is in out-of-home care and requires intensive home based care to achieve the reintegration plan.

**I.2.0 Continued Care Criteria**

All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the Department's definition of medical necessity and, for anyone under 21, does not meet the EPSDT criteria.

- I.2.1 Child/Adolescent has met admission criteria for the previously approved level of MDFT as evidenced by:
  - I.2.1.1 The child /adolescent 's symptoms or behaviors persist at a level of severity documented at the most recent start for this episode of care; or
  - I.2.1.2 The child/adolescent's symptoms or behaviors persist at a level of severity adequate to meet admission criteria; or
  - I.2.1.3 The child/adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or
  - I.2.1.4 The child /adolescent's symptoms have increased sufficiently over the past 24 hrs to warrant immediate increase of number of hours provided weekly to the family/caregiver, and
- I.2.2 Evidence of active treatment and care management as evidenced by:
  - I.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and
  - I.2.2.2 Child and family/ caregiver participation in treatment is consistent with care plan, or active efforts to engage the child/adolescent and/or family/caregiver are in process. Type, frequency and intensity of services are consistent with treatment plan, and
  - I.2.2.3 Efforts are being made to affect a timely transition to outpatient care (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments).
- I.2.3 If child/adolescent does not meet criterion I.2.2, continued treatment may still be authorized under any of the following circumstances:
  - I.2.3.1 Child/Adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through home-based treatment and continued home based treatment in current setting is determined necessary in order for the



discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or

I.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives is necessary to enable the child/adolescent to be discharged to a less intensive level of care; or

I.2.3.3 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been pursued but are not available (including but not limited to such resources as placement options, clinical and non-clinical support, day treatment or intensive outpatient treatment etc). Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with DCF or directly with local providers or Community Collaboratives to address aftercare needs).

**Note:** Making of Level of Care Decisions

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

# Multisystemic Therapy

## Level of Care Guidelines

### Definition

Multisystemic Therapy (MST) is an evidence based treatment model designed to divert children and adolescents ages 11 to 17 from residential substance use disorder and Juvenile Justice treatment systems or to support discharge from inpatient levels of care. While children/adolescents with disruptive behavioral and/or substance use disorder symptoms are the focus of intervention, the model relies on ecological, family and systemic interventions to assist in the reduction of symptoms.

MST is an intensive home-based delivery system with an emphasis on the engagement and retention of the family/caregiver, the recovery environment, and providing integrated case management. MST has developed fidelity measures based on research and MST principles as well as quality assurance systems to manage program drift.

### Authorization Process and Time Frame for Service

This level of care requires prior authorization and can only be provided by a treatment provider who is an MST credentialed provider, certified by the Department of Children and Families.

Initial authorization period is 630 units over 6 months. Typically, the service is 1 to 5 contacts per week. Authorization of significant additional contact per week may be required in certain instances to respond to the needs of the child/adolescent and family/caregiver. In these cases, more frequent review with a care manager will be required. Services may last up to five months, or beyond with special review.

### Level of Care Guidelines

#### J.1.0 Admission Criteria

J.1.1 Symptoms and functional impairment include all of the following:

J.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention.

J.1.1.2 Symptoms and impairment must be the result of a primary substance use disorder and/or disruptive behavior disorder: internalizing psychiatric conditions may be secondary.

J.1.1.3 Functional impairment not solely a result of Autism Spectrum Disorder or Intellectual Disability,

J.1.2 Presentation consistent with at least one of the following:

J.1.2.1 Recent and/or ongoing risk of deliberate attempts to inflict serious injury on another person; or

J.1.2.2 Recent and/or ongoing dangerous or destructive behavior as evidenced by indication of episodic impulsivity or physically or sexually aggressive impulses that are endangering to self or others (e.g., impulsive acts while intoxicated, running away from home or placement with voluntary return, fire setting, violence toward animals, affiliation with dangerous peer groups); or

J.1.2.3 Recent and/or ongoing substance use disorder that is interfering with the child's/adolescent's psycho-social functioning in the community.

J.1.3 Children/Adolescents appropriate for MST services are those for whom:

J.1.3.1 There is a family/caregiver resource that is available to participate in this intensive home-based intervention, and

J.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety, and

J.1.3.3 A safety plan has been established, and

J.1.3.4 The primary presenting problem is not an internalizing disorder or the child/adolescent is not actively psychotic or suicidal.

J.1.4 Intensity of Service Need

J.1.4.1 The child/adolescent has been admitted to, or is at risk of being admitted to a substance use disorder and/or Juvenile Justice residential level of care or is being discharged from a treatment center and demonstrated the above admission criteria prior to placement and

J.1.4.2 The child/adolescent's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves family members/caregivers as primary intervention specialists and

- J.1.4.3 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community-based care as evidenced by one of the following:
  - J.1.4.3.1 Recent attempts to engage the child/adolescent and/or family/caregiver in intensive outpatient therapy have been unsuccessful or
  - J.1.4.3.2 The above problems occur in context of the ecology and recovery environment is a significant factor to initiate and maintain clinical gains or
  - J.1.4.3.3 The child/adolescent is in out of home care and requires intensive in-home care to achieve the reintegration plan.

## J.2.0 Continued Care Criteria

- J.2.1 The child/adolescent has met admission criteria within the past thirty (30) days for MST as evidenced by:
  - J.2.1.1 The child/adolescent's symptoms or behaviors persist at a level of severity adequate to meet admission criteria, or
  - J.2.1.2 The child/adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or
  - J.2.1.3 The child/adolescent 's symptoms have increased sufficiently over the past 24 hours to warrant immediate increase of number of hours provided weekly to the family/caregivers and
- J.2.2 Evidence of active treatment and care management as evidenced by:
  - J.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established. Treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly, and
  - J.2.2.2 Child/adolescent and family/ caregiver participation in treatment is consistent with care plan, or active efforts to engage the child/adolescent and/or family/caregivers are in process. Type, frequency and intensity of services are consistent with treatment plan, and
  - J.2.2.3 Vigorous efforts are being made to affect a timely transition to appropriate lower level of care.

J.2.3 If child/adolescent does not meet criterion E.2.1, continued treatment may still be authorized under any of the following circumstances:

J.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through continued home-based treatment and such treatment is necessary in order for the discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or

J.2.3.2 Child/Adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to a less intensive community rather than to a more restrictive setting; or

J.2.3.3 Child/Adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, substance use disorder treatment or therapist appointments, therapeutic mentoring, etc). Authorization may be extended for up to 10 days. Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with DCF if child is DCF involved or directly with local providers or Community Collaboratives to address aftercare needs).

**Note:** Making of Level of Care Decisions

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

# Functional Family Therapy

## Level of Care Guidelines

### Definition

Functional Family Therapy (FFT) is a manualized treatment model designed to prevent children and adolescents ages 11-17, from requiring psychiatric hospitalization or residential placement or to support discharge from these out-of-home levels of care.

The FFT model is a home-based service designed to address both symptoms of serious emotional disturbance in the identified child/adolescent as well as parenting practices and/or other family/caregiver challenges that affect the child/adolescent and family's/caregiver's ability to function.

During the FFT intervention, efforts are made to address areas in addition to child/adolescent functioning and family/caregiver relationships that may contribute to the child's/adolescent's psychosocial adversity. Particular areas include the school environment as well as the family's/caregiver's involvement with formal and naturalistic supports and services.

It is expected that FFT clinicians will take an active role in working directly with children/adolescents and their families/caregivers as well as in managing their care and facilitating health-enhancing connections in the community.

### Authorization Process and Time Frame for Service

This level of care requires prior authorization and can only be provided by a treatment provider who is credentialed as an FFT provider and certified by the Department of Children and Families as an FFT provider.

Initial authorization period is 324 units over 6 months. Typically, the service is 1 to 2 contacts per week. Authorization of significant additional contact per week may be required in certain instances to respond to the needs of the child/adolescent and family/caregiver. In these cases, more frequent review with a care manager will be required. Services may last up to five months or beyond with special review.

This level of care may be concurrently authorized with other levels of care such as outpatient, intensive outpatient or extended day treatment based on the individual needs of the child/adolescent and family/caregiver. This level of care may not be authorized concurrently with other intensive home-based behavioral health services, including Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Multidimensional Family Therapy (MDFT), and Multisystemic Therapy (MST).

### Level of Care Guidelines

#### **K.1.0 Admission Criteria**

K.1.1 Symptoms and functional impairment include all of the following:

K.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention,

K.1.1.2 Symptoms and impairment must be the result of a primary psychiatric disorder and substance abuse disorders may be secondary,

K.1.1.3 Functional impairment not solely a result of Autism Spectrum Disorder or Intellectual Disability.

K.1.2 Presentation consistent with at least one of the following:

K.1.2.1 Recent and/or ongoing marked depression, anxiety, or withdrawal from activities and relationships and peers; or

K.1.2.2 Recent and/or ongoing marked mood lability as evidenced by frequent or abrupt mood changes accompanied by verbal or physical outbursts/aggression and/or destructive behaviors; or

K.1.2.3 Recent and/or ongoing dangerous or destructive behavior as evidenced by episodic impulsivity or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g., impulsive acts while intoxicated, self-injurious behavior, running away from home or placement with voluntary return, fire setting, violence toward animals, affiliation with dangerous peer groups).

K.1.3 Children/Adolescents appropriate for FFT services are those for whom:

K.1.3.1 There is a family/caregiver resource that is available and willing and able to participate in this intensive home-based intervention, and

K.1.3.2 Arrangements for supervision at home are adequate to assure a reasonable degree of safety, and

K.1.3.3 There is a crisis plan in place, and

K.1.3.4 The primary presenting problem is *not* recent and/or ongoing suicidal gestures and/or attempts; or recent and /or ongoing self- injurious behavior that is serious and dangerous; or recent and/or ongoing risk of deliberate attempts to inflict serious injury on another person; or recent and/or ongoing psychotic symptoms or behavior that poses a moderate risk to the safety of the child/adolescent or others (e.g., hallucination, marked impairment of judgment).

**K.1.4 Intensity of Service Need**

K.1.4.1 The child's/adolescent's successful maintenance or reintegration in the community is dependent upon an integrated and coordinated

treatment approach that involves family members/caregivers as primary intervention specialists; and

K.1.4.2 The above symptoms cannot be contained, attenuated, evaluated and treated in a lower level of community-based care as evidenced by one of the following:

K.1.4.2.1 Recent attempts to engage the child/adolescent and/or family/caregivers in outpatient therapy have been unsuccessful due to transportation issues and/or other family/caregiver constraints that interfere with ability to keep appointments on a consistent basis; or

K.1.4.2.2 The above problems occur in the context of a regular and significant outpatient therapeutic relationship despite efforts to augment such treatment (e.g., medication consultation or increased outpatient therapy visits or addition of family/caregiver therapy, psychological assessment, group therapy, etc.) or

K.1.4.2.3 The child/adolescent is in out of home care and requires intensive home-based care to achieve the reintegration plan.

## K.2.0 Continued Care Criteria

K.2.1 Child/adolescent has met admission criteria for the previously approved level of FFT as evidenced by

K.2.1.1 The child/adolescent's symptoms or behaviors persist at a level of severity adequate to meet admission criteria; or

K.2.1.2 The child/adolescent has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals; or The child/adolescent's symptoms have increased sufficiently over the past 24 hours to warrant immediate increase of number of hours provided weekly to the family/caregivers, and

K.2.2 Evidence of active treatment and care management as evidenced by:

K.2.2.1 A care plan with evaluation and treatment objectives appropriate for this level of care has been established, treatment objectives are related to readiness for discharge and progress toward objectives is being monitored weekly; and

K.2.2.2 Child/Adolescent and family/ caregiver participation in treatment is



consistent with care plan, or active efforts to engage the child/adolescent and/or family/caregivers are in process. Type, frequency and intensity of services are consistent with treatment plan; and

K.2.2.3 Vigorous efforts are being made to affect a timely transition to outpatient care, when such care is consistent with the treatment plan (e.g., meeting with caseworker, convening aftercare planning meetings with aftercare providers, identifying resources and referring for aftercare or care coordination, scheduling initial aftercare appointments); and

K.2.2.4 Children/Adolescents receiving FFT services can receive concurrent treatment from other mental health providers including, but not limited to, outpatient, extended day, and partial hospital services if deemed appropriate in the treatment plan.

K.2.3 If child/adolescent does not meet criterion, continued treatment may still be authorized under any of the following circumstances:

K.2.3.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved through continued home-based treatment and such treatment is necessary in order for the discharge plan to be successful and there is no less intensive level of care in which the objectives can be safely accomplished; or

K.2.3.2 Child/adolescent can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to a less intensive community-based level of care rather than to a more restrictive setting; or

K.2.3.3 Child/adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including, but not limited to, such resources as placement options, psychiatrist or therapist appointments, therapeutic mentoring, etc). Authorization may be extended based on the individual clinical needs of the child/adolescent. Child/adolescent should be referred to Intensive Care Management. (Intensive Care Manager will work with DCF if child is DCF involved or directly with local providers or Community Collaboratives to address aftercare needs).

**Note:** Making of Level of Care Decisions

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer

must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

# Outpatient Level of Care Guidelines

## Definition

Outpatient therapy services are ambulatory clinical services provided by a general hospital, private freestanding psychiatric hospital, psychiatric outpatient clinic, school-based health clinic, state-operated facility, or by a licensed mental health practitioner practicing independently or in a private practice group. This service involves the evaluation, diagnosis, and treatment of individuals, families or groups as well as medication management. Services are typically scheduled in advance, but may occur urgently without a scheduled appointment. Services are provided at a frequency designed to address immediate clinical need as directed by a child/adolescent or family/caregiver treatment plan. Outpatient services are designed to promote, restore, or maintain age appropriate social/emotional functioning and are intended to be focused and time limited with services discontinued as the child/adolescent and family/caregivers are able to function more effectively.

A child/adolescent can receive services from more than one provider (e.g., clinic, independent practitioner) at any given time offering individual, family, group or medication management services, provided the services are not duplicative. Based on clinical necessity and with review by a care manager, a child/adolescent may be authorized to receive an outpatient service while simultaneously participating in a higher level of care.

## Authorization Process and Time Frame for Service

Registration is required which results in an initial authorization of ninety (90) sessions covering a twelve-month period of time. Visits in excess of 90 or those beyond the initial twelve-month period would require continued stay registration.

## Level of Care Guideline:

### L1.0 Admission Criteria:

#### L1.1 Symptoms and functional impairment include all of the following:

- L.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention,
- L.1.1.2 Symptoms and impairment must be the result of a psychiatric or Substance abuse disorder and
- L.1.1.3 Functional impairment not solely a result of an Intellectual Disability.

**L12 Intensity of Service Need**

- L.1.2.1 Child/adolescent is experiencing behavioral and/or emotional problems as described in the most recent DSM that can be assessed or safely addressed in an outpatient setting using one or more of the treatment modalities defined above.

**L20 Continued Care Criteria**

- L21 The child/adolescent has met criteria for outpatient care and there is evidence of active treatment and care management as evidenced by:

- L.2.1.1 Child/Adolescent and family/caregiver participation in treatment consistent with care plan, or active efforts to engage the child/adolescent and/or family/caregiver are in process. Type, frequency and intensity of services are consistent with treatment plan, and
- L.2.1.2 A care plan with evaluation and treatment objectives appropriate for this level of care has been established and treatment objectives are related to readiness for discharge, progress towards objectives is being monitored and the child/adolescent is making measurable progress but identified objectives have not yet been met.

- L22 If the child/adolescent does not meet criteria listed above, additional outpatient services may be authorized if either of the following are true:

- L.2.2.1 There is evidence that the child/adolescent will not be able to maintain functioning without sustained or significant deterioration if treatment is discontinued; or
- L.2.2.2 There is an anticipated stressor within the child's/adolescent's immediate social or family environment that, based on clinical history, could reliably predict behavioral and emotional regression (i.e., impending birth of sibling, divorce of parents, scheduled medical procedure, change in home environment, etc.)

- L23 The child/adolescent/family/caregiver does **not** meet continued care criteria if:

- L.2.3.1 The child/adolescent has met treatment goals or the child/adolescent /family/caregiver has demonstrated minimal or no progress toward treatment goals for a three month period and appropriate modifications of treatment plan have been made and implemented with no significant success, suggesting the child/adolescent/family/caregiver is not benefiting from outpatient therapy services at this time.

**Note: Making of Level of Care Decisions**

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases, the child/adolescent shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.

# Psychological and Neuropsychological Testing – Youth Level of Care Guidelines

## **Definition**

Psychological Testing involves the administration and interpretation of standardized tests used to assess an individual's psychological or cognitive functioning. It assists in gaining an understanding of an individual's diagnostic presentation and informs the appropriate course of treatment. Psychological evaluation using various measures may be conducted to clarify a psychiatric diagnosis in situations in which: 1) there is current symptomatic behavior or medical condition that disrupts functioning and, 2) there is a lack of diagnostic clarity that cannot be resolved by standard interview techniques and, 3) this lack of diagnostic clarity is preventing the development or revision of an appropriate treatment plan. Results would be used to determine the best possible treatment approaches, clarify specific child/adolescent needs, identify child/adolescent strengths, or distinguish necessary interventions for best clinical utility.

Common types of tests are: projective and/or objective personality assessments, intelligence assessments, adaptive living scales, and neuropsychological assessments.

All testing must be done in accordance with the American Psychological Association's Standards for Educational and Psychological Testing. As such, testing must be administered and interpreted by a licensed psychologist and any measure used must have documented standardization, reliability, and evidence that it is appropriate for its intended use and that it enhances diagnostic accuracy. Test results will lead to child/adolescent specific clinical recommendations that will be shared with family/caregivers and collateral contacts with appropriate release of information as indicated.

## **Authorization Process and Time Frame for Service**

This service requires prior authorization through the submission of a Request for Psychological Testing form. Requests for psychological testing must target specific diagnostic questions and address the reasons why standard interview techniques or therapies cannot resolve those questions. All children/adolescents referred for psychological or neuropsychological testing and their family/caregivers may require a preliminary diagnostic interview by the Psychologist scheduled to perform the testing. This interview will allow the Psychologist to identify the specific test instruments needed to address the referral issues. Once the preliminary diagnostic interview is completed, the psychologist will complete the Request for Psychological Testing Form. Authorization for this service will be granted not more frequently than once every 12 months unless there is compelling evidence of marked change and 1) there is substantial clinical reason to suspect organic or trauma related deterioration or 2) previous test results are deemed invalid due to inappropriate administration or 3) child/adolescent performance was impaired by issues that were unknown to the psychologist at the time of test administration (i.e., child/adolescent was becoming physically ill, child/adolescent had recently been traumatized).

## **Level of Care Guidelines**

### **M.1.0 Admission Criteria**

#### **M.1.1 Severity of Symptoms and Functional Impairment**

- M.1.1.1 The child/adolescent has or is believed to have a diagnosable behavioral health disorder, (neuropsychological testing should be performed for the diagnosis and treatment of an organic disorder) and
- M.1.1.2 Child/Adolescent evidences significant functional impairment secondary to the above disorder, and

#### **M.1.2 Intensity of Service Need**

- M.1.2.1 One or more of the following criteria must be met:
  - M.1.2.1.1 Traditional clinical assessment has not proven effective in identifying the underlying cause for the child's/adolescent's behavioral distress and testing is needed to determine diagnosis and the most appropriate course of treatment; or
  - M.1.2.1.2 The child/adolescent has not responded to traditional treatment without a clear explanation of treatment failure and testing is necessary to address issues related to differential diagnosis, or
  - M.1.2.1.3 The testing will have a timely effect on the revised treatment planning process.

#### **M.1.3 Additional Variables to be Considered:**

- M.1.3.1 Valid testing was not administered within the last year or there is sufficient justification for repeat/additional testing, and
- M.1.3.2 Testing is not routine but medically necessary, and
- M.1.3.3 Primary purpose of testing is not for educational, vocational, or legal purposes, and
- M.1.3.4 The child/adolescent is not under the influence of alcohol or other substances, undergoing detoxification, or experiencing residual or temporary effects of substance use that are likely to compromise the validity of testing, and
- M.1.3.5 Symptoms of acute psychosis will not interfere with proposed testing validity, and

- M.1.3.6 The time requested for test/test battery does not fall outside of the manufacturer's or the Clinical Management Committee's recommended time frames.

**M.2.0 Continued Care Criteria – Not applicable Note:**

Making Level of Care Decisions

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases, the patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.



## **Case Management Services – Youth under 21 years of age Level of Care Guidelines**

### **Definition**

The federal definition of “case management services” means services that will assist individuals in gaining access to needed medical, social, educational and other services. Case management is a system to centralize coordination of care for a client allowing more effective and efficient use of resources. Children/Adolescents who are eligible for Case Management services must have a DSM diagnosis. They generally are involved with multiple systems such as multiple mental health providers, physical health providers, school and/or work. Case Management entails referring, linking, coordinating, monitoring and evaluating the effectiveness of services from those multiple systems.

Case management services can either be face-to-face meetings or telephone contacts with external agencies, providers, families, DCF, school systems or other community resources in which the focus is the current treatment of the child/adolescent. The child/adolescent or family/caregiver may or may not be present. The child’s/adolescent’s treatment plan or case management care plan must specify the goals and actions necessary to address the medical, social, educational and other services needed by the child/adolescent to support symptom reduction and improvement in functioning. Each case management episode must be appropriately documented to indicate how it supports the goals of the child’s/adolescent’s treatment plan. Services included under case management are (1) activities that help to determine the need for any medical, educational, social or other services such as taking history, identifying the needs of the child/adolescent and/or family/caregiver and completing related documentation, gathering information from other sources such as family members, medical providers, social workers and educators to form a complete assessment of the child/adolescent; (2) development of a specific care plan based on information collected through an assessment; (3) referral and related activities to help a child/adolescent and/or family/caregiver obtain needed services; (4) monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the child/adolescent and/or family/caregiver. Other included services are time spent writing letters to DCF or the courts providing treatment summaries and recommendations that include living arrangements and treatment options or time spent in court testifying or working with the family in preparation for the court process. Services not included under case management include contacting CT BHP for authorization for services, routine documentation of treatment sessions or other direct medical services, and routine case reviews and rounds as part of regular clinic work.

Case management services must be provided by an independent practitioner or individual qualified to provide clinical services at a freestanding mental health or substance abuse clinic unless case management is being performed under a DCF approved home-based service program which is described in separate level of care guidelines. The case manager may work in collaboration with a Care Coordinator from a local Community Collaborative or DCF social worker, but case management work may not be duplicative and should facilitate achievement of case management goals.

## **Authorization Process and Time Frame for Service**

Providers will receive 12 units (3 hours) of case management per year without prior authorization. Anything beyond 12 units (3 hours) requires prior authorization. This service may only be provided in conjunction with routine outpatient services or rehabilitation services.

## **Level of Care Guideline**

### **N.1.0 Admission Criteria**

N.1.1 Symptoms and functional impairment include all of the following:

- N.1.1.1 Diagnosable behavioral health disorder, according to the most recent ICD, which requires and can be reasonably expected to respond to therapeutic intervention,
- N.1.1.2 Symptoms and impairment must be the result of a psychiatric or substance abuse disorder,
- N.1.1.3 Functional impairment not solely a result of an Intellectual Disability,

N.1.2 Intensity of Service Need

- N.1.2.1 The clinician has described specific case management activities that can reasonably be expected to improve progress toward treatment goals.

### **N.2.0 Continued Care Criteria**

N.2.1 The case management activities involve services that are needed or services must be adjusted to support progress without which the child/adolescent will not be able to maintain functioning or there will be deterioration

N.2.2 The child/adolescent does **not** meet continued care criteria if:

- N.2.2.1 The child/adolescent has met case management goals or the child/adolescent and/or family/caregiver has demonstrated minimal or no progress toward case management goals including active participation in the services that are the focus of case management.

### **Note: Making Level of Care Decisions**

In any case, in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making Level of Care Decisions and in these cases, the

patient shall be granted the level of care requested when:

- 1) Those mitigating factors are identified and
- 2) Not doing so would otherwise limit the patient's ability to be successfully maintained in the community or is needed in order to succeed in meeting patient treatment goals.