

COMMCARE
Community Network for Behavioral Healthcare, Inc.

Care Management Guidelines

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The Community Network for Behavioral Healthcare, Inc. (CommCare) has developed the following *Care Management Guidelines* to assist clinical staff in matching clients with those services appropriate to assessed need(s). They are to be used as a general guide since not all cases will fall into the outlined clinical criteria.

Utilization Management

1.1 Adult Services

- Inpatient Services
- Extended Observation Unit (23-Hour)
- Partial Hospital Services
- Intensive Outpatient Services
- Psychological Evaluation

1.2 Youth Services

- Inpatient Services
- Extended Observation Unit (23-Hour)
- Partial Hospital Services
- Sub-Acute Program
- 3-Day Rapid Evaluation
- Psychological Testing

2.1 Adult Services

Crisis Intervention
Crisis Respite Services
Outpatient Psychotherapy/Counseling Services
Community Case Management (Service Coordination)
Medication Management
Psychoeducation Groups
Psychiatric Evaluation

2.2 Youth Services

Crisis Intervention
Crisis Respite Services
Outpatient Psychotherapy/Counseling Services
Medication Management
Community Case Management (Service Coordination)
Psychoeducation Groups
Wraparound Services
Behavioral Management Services
In-Home Services

2.3 Substance Abuse Services

Social Setting Detoxification
Intensive Outpatient Services
Outpatient Services

Adult Services

COMMCARE
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Adult Placement Criteria

Inpatient Services (Revenue Code: 124)

<i>Definition of Service</i>	A twenty-four hour protected psychiatric treatment environment, designed for those individuals who are a significant danger to themselves or others, or who are significantly disabled and cannot meet their basic needs and role functions.
<i>Service Components</i>	Physician (psychiatric) services; Nursing services; Medication administration/monitoring; Counseling (individual, family, group); Case management and Discharge planning
<i>Documentation</i>	<i>Psychiatric Evaluation; Physical Examination; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Community Based Alternatives</i>	Crisis Intervention Services; Extended Observation Unit (23-Hour Services); Partial Hospital; Crisis / Respite Care.

Provider Type(s)	Inpatient Psychiatric Facilities shall be JCAHO accredited
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis
An individual may be appropriate for hospitalization if at least one of the following is present:
1. The individual has recently made a suicide attempt with lethal intent.
2. The individual expresses suicidal ideation with a definite plan and remains at high risk for self-harm. The individual is unable to contract for a "no self harm" agreement.
3. The individual presents as a potential danger to others. The individual may be expressing homicidal ideation or have recent history of extreme acts or threats of physical aggression or fire settings as examples.
4. The presence of severe cognitive impairment/disorientation resulting in impaired judgment that could place the individual in danger to harm self or others.
5. The presence of acute or marked worsening or psychotic symptoms such as hallucinations, delusion or paranoia. These may influence the individual's insight or judgement and place the client in danger to self or others.
6. The individual is unable to maintain adequate nutrition, shelter and or essentials of daily living due to a psychiatric disorder and family/community support are not immediately available.
7. The presence of a severe intoxicated/withdrawal state when no other unit is capable of providing adequate treatment. In this state the individual cannot make appropriate decisions to insure safety and/or may be at risk for medical complications. Examples of this may include PCP intoxication or delirium tremors. For Any Substance the Following: a. B.P. >140/90 b. Pulse >100 c. Seizures/Hx of seizures d. Delirium Tremens/Hx of D.T.s (severe cases may require medical transfer) e. Acute paranoia/withdrawal hallucinosis f. Suicidal ideation/severe depression g. Severe sleep pattern disturbance h. Cardiac problems or Hx of cardiac problems i. Continuous use of two (2) or more substances Additional Parameters by Substance Type (any symptom present): Stimulants (Methamphetamines, cocaine): Paranoia, lability, palpitations, diaphoresis, chest pain Opioids and related alkaloids: Diarrhea, severe abdominal cramps, severe joint pain Club Drugs (Ecstasy, GHB, LSD)

Dehydration, disorientation Inhalants, PCP and marijuana with chemical additives Psychosis, aggression, confusion, severe impulsivity Benzodiazepines Addicted to high daily doses
8. The individual requires 24 hour nursing care and physician involvement for the evaluation and treatment process.
9. The individual has a history of self - injury such as self-mutilation, suicide gesture or placing self in extremely dangerous situations.

Criteria for Certification Change

The individual no longer meets certification criteria or meets criteria for less intensive level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the individual has been developed and explained to the client/guardian.

COMMCARE
Community Network for Behavioral Healthcare, Inc.

Adult Placement Criteria

Extended Observation Unit (Revenue Code: 762)

<i>Definition of Service</i>	A protected psychiatric treatment environment in which the client can remain for up to 23 hours. This service is designed for those individuals who are in acute emotional distress. The purpose of the modality is to determine whether the distress is related to a transitory situation, which is, resolved when the individual is provided with structure and treatment interventions.
<i>Service Components</i>	Physician (psychiatric) services; Nursing services; Medication administration/monitoring; Crisis counseling; Case management and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Crisis Intervention Services; Partial Hospital; Crisis / Respite Care.

Provider Type(s)	Inpatient Psychiatric Facilities shall be JCAHO accredited
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis
1. The individual verbalizes potential danger to others or self, however, does not have a plan or access to means.
2. The individual has a history of poor impulse control and responds positively to brief removal from situation into structured, safe environment.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

COMMCARE
Community Network for Behavioral Healthcare, Inc.

Adult Placement Criteria

Crisis Respite Services (Revenue Code: 660)

<i>Definition of Service</i>	Provision of a twenty-four hour living environment with is supportive, structured, clean and safe for individuals who are experiencing a psychiatric crisis.
<i>Service Components</i>	Protective oversight; Access to a QMHP on an on-call basis; Medication administration/monitoring; Crisis counseling; Case management and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Extended Observation Unit; Crisis Intervention Services; Partial Hospital; Respite Care.
Provider Type(s)	DMH approved group homes; Sheltered Apartments; RCF's

Criteria for Certification

1. The individual has a DSM IV Axis I diagnosis.
2. The individual is not of imminent danger to self or others.
3. The individual is not under the influence of drugs or alcohol.
4. The individual is experiencing psychiatric crisis that may, without intervention, lead to hospitalization.
5. The individual is in need of continuous oversight and/or medication monitoring.
6. Adequate family/social support is not available within the individual's present environment.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

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Adult Placement Criteria

Partial Hospital Services (Revenue Code: 912 Full Day; 910 Half Day)

<i>Definition of Service</i>	A time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. This service is for individuals who are able to remain in the community and present no imminent potential for harm to themselves or others within the structure of 6-8 hours of programming per day, (availability 5-7 days per week.).
<i>Service Components</i>	Psychiatric Services; Nursing Services; Medication administration/monitoring; Counseling; Case management and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Extended Observation Unit; Crisis / Respite Services; Intensive Outpatient Services.

Provider Type(s)	Inpatient Psychiatric Facilities; Community Mental Health Centers
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
An individual may be appropriate for psychiatric partial hospitalization if at least one of the following is present:
1. Suicidal ideation or threat with no intent to harm self. The individual is willing to contract for a "no self harm" agreement.
2. Individual has thoughts of harming others but no specific plan or intent. The individual is willing to contract for "no harm" toward others.
3. The individual has a recent history of self-injury such as self-mutilation or other high-risk behaviors.
4. The presence of mild, acute or worsening of psychotic symptoms such as hallucinations, delusions or paranoia. The individual maintains insight and judgment and is not in any acute danger to self or others.
5. The individual is able to maintain adequate nutrition, shelter and essentials of daily living only with the structure and supervision provided in the treatment setting for a significant portion of the day.
6. Psychologically functioning is too tenuous to return to full work/family/school activities. The individual requires ongoing structure and supervision in the treatment setting for a significant portion of the day.
Routine nursing and medical observation is required but less than 24 hours a day.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems that allow client to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

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Adult Placement Criteria

Intensive Outpatient Services (Revenue Code: 915)

<i>Definition of Service</i>	A structured clinical program for clients with moderate disorders who required a time-limited, ambulatory, active treatment program that offers therapeutically coordinated, structured clinical services within a stable therapeutic milieu. Generally IOP services provide nine or more hours of services per week.
<i>Service Components</i>	Medication monitoring; Counseling; Case management and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Partial Hospital Services; Outpatient Counseling

Provider Type(s)	Community Mental Health Centers; Qualified Mental Health Professionals; Bachelor's Degree (Case Management only)
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
1. The individual has a community -based network of support that assists in maintaining him/her within the community.
2. The individual requires monitoring, support and on-going therapeutic interventions.
3. There is an identifiable stressor associated with the alteration of normal level of functioning.
4. The individual is able to exhibit adequate control over behaviors and is judged not to be of imminent danger to self or others.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The client has reached maximum clinical benefit from this level of care or
Support systems that allow client to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

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Adult Placement Criteria

Outpatient Psychotherapy/Counseling Services

- CPT Codes:** 90804 *Individual Psychotherapy (20-30 Minutes)*
90805 *Individual Psychotherapy with Medication Evaluation and Management (20-30 Minutes)*
90806 *Individual Psychotherapy (45-50 Minutes)*
90807 *Individual Psychotherapy with Medication Evaluation and Management (45-50 Minutes)*
90853 *Group Therapy*
90846 *Family Therapy (without Client)*
90847 *Family Therapy (with Client)*

<i>Definition of Service</i>	Solution-oriented counseling services designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interfere with a client's personal, familial, vocational or community adjustment.
<i>Service Components</i>	Individual; Family; or Group Counseling/Therapy
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Intensive Outpatient Services; Psychoeducational services; Support groups

Provider Type(s)	Psychiatrists; Licensed Psychologists; Licensed Social Workers; Licensed Professional Counselors; QMHP supervised by a Licensed Mental Health Professional
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
1. There is an expectation that the prescribed treatment will show significant progress toward treatment goals within the specified number of sessions.
2. There are significant symptoms that interfere with the individual's ability to function in more than one life area.
3. The individual demonstrates motivation to comply with treatment.
4. There is an identifiable stressor associated with the alteration of normal level of functioning.
5. The mode of treatment is appropriate to the disorder.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the individual's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
The individual is not compliant with their <i>Individualized Treatment Plan</i> .

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Adult Placement Criteria

Community Case Management / Service Coordination (CPT Code: 99362)

<i>Definition of Service</i>	Coordination of services to assist clients in maintaining therapeutic gains and progressing toward less intensive services.
<i>Service Components</i>	Coordination and implementation of the <i>Individualized Treatment Plan</i> , including identification of community resources and linkage to services, arranging for or providing appropriate supports to assist the individual in accessing community resources and facilitating communication among all service providers.
<i>Documentation</i>	<i>Progress Notes</i> which clearly reflect treatment plan implementation
<i>Alternative Services</i>	Outpatient Psychotherapy/Counseling Services; Support groups

Provider Type(s)	QMHP; Bachelor's Level under supervision of a QMHP
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
1. The individual requires access to appropriate services and support to be maintained within the community.
2. The individual has a history of frequent use of highly intensive services or is judged to be at risk.
3. The individual receives services from multiple providers/systems requiring coordination to ensure continuity of care.

Criteria for Certification Change

The goals/objectives identified on the individual's <i>Individualized Treatment Plan</i> have been accomplished or
The agreed upon termination date has arrived or
Lack of significant progress toward expected goals or
The individual is not compliant with their <i>Individualized Treatment Plan</i> .

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Adult Placement Criteria

Medication Management (CPT Code: 90862)

<i>Definition of Service</i>	Psychotropic medication adjustment and monitoring services.
<i>Service Components</i>	Prescription for psychotropic medications, review of the effects and side effects, and adjustment of the type and dosage of psychotropic medications prescribed that address the therapeutic goals identified in the <i>Individualized Treatment Plan</i> .
<i>Documentation</i>	<i>Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect treatment plan implementation
<i>Alternative Services</i>	Outpatient Services; Case Management; Psychoeducational Services; Support Groups

Provider Type(s)	Psychiatrist; Advance Practice Nurse under the direction of a Psychiatrist
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
1. There has been no reduction of symptoms in response to psychotherapeutic interventions.
2. If currently abusing alcohol or other drugs, the individual agrees to substance abuse treatment.
3. Individual makes an informed choice and agrees to take medication.
4. Symptoms are known to respond to medication i.e. anxiety, disordered thinking, mood disturbances, etc.

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Adult Placement Criteria

Psychiatric Evaluation

CPT Codes: 90801 Psychiatric Diagnostic Interview
90802 Interactive Psychiatric Diagnostic Interview (Child Assessment utilizing play equipment, etc)

<i>Definition of Service</i>	A diagnostic examination primarily utilized to assess client's need for psychotropic medication, consultation regarding treatment interventions(s) or when the diagnosis is in question.
<i>Service Components</i>	Psychosocial and psychiatric history, mental status and disposition.
<i>Documentation</i>	<i>Evaluation Report</i> , including axis I - V diagnostic formulation and treatment recommendations.
<i>Alternative Services</i>	Non-applicable

Provider Type(s)	Psychiatrist
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Criteria for Certification

1. An initial assessment has been conducted by a licensed clinician or QMHP
2. The individual requires assessment re: psychotropic medication
3. An assessment is required to identify medical condition(s) that may cause psychiatric symptoms or
4. An assessment is required to clarify diagnosis or to provide consultation regarding treatment intervention.

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Adult Placement Criteria

Crisis Intervention (CPT Code: 90899)

<i>Definition of Service</i>	Emergency/crisis behavioral health services that are available 24 hours a day.
<i>Service Components</i>	Services may include evaluation and counseling to stabilize the situation, psychotropic medication stabilization, support services and/or other therapeutic activities to reduce or eliminate the emergency situation.
<i>Documentation</i>	Completion of a <i>Crisis Contact Sheet</i> reflecting intervention(s) and disposition and <i>Risk Assessment Form</i>
<i>Alternative Services</i>	Outpatient Services; Case Management; Psychoeducational Services; Support Groups
<i>Provider Type(s)</i>	Qualified Mental Health Professional (Treatment Interventions); Bachelor's Level under supervision of QMHP (Support Services)

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Adult Placement Criteria

Psychological Evaluation (Testing) (CPT Code: 96100)

<i>Definition of Service</i>	Assessment of a client in response to diagnostic or treatment questions.
<i>Service Components</i>	A problem-focused clinical interview and administration/interpretation of standardized tests.
<i>Documentation</i>	A written report which addresses the diagnostic/treatment question and provides treatment recommendations
<i>Alternative Services</i>	Psychiatric Evaluation; Assessment by a Licensed Mental Health Professional

Provider Type(s)	Licensed Psychologist
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Criteria for Certification

Requests for psychological evaluations must be submitted in writing and address the specific diagnostic/treatment question. All requests will be reviewed individually.
Note: All requests for educational purposes will be denied.

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Adult Placement Criteria

Psychoeducational Groups (CPT Code: 90853)

<i>Definition of Service</i>	Educational groups designed to provide participants with skills to enhance their functioning. Examples include: Stress Management; Parenting; Problem-Solving; Symptom management (anxiety, depression, etc).
<i>Service Components</i>	Didactic presentation; Group discussion; Handouts (optional); Homework Assignments (Optional)
<i>Documentation</i>	Program curriculum; Participation Log
<i>Alternative Services</i>	Outpatient Psychotherapy; Medication Management

Provider Type(s)	Qualified Mental Health Professional; Bachelor's Level under supervision of a QMHP
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis and
The individual presents with mild or moderate symptoms that interfere with their functioning in one or more life area or
There is an identifiable stressor associated with the alteration to the individual's normal functioning and
The individual has the cognitive capability to learn new skills.

Children and Youth Services

Note: Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services contractors (CMHC's) may provide and invoice DMH for CPRP, Wrap-Around and Respite services provided to seriously emotionally disturbed children and youth who are enrolled in MC+ and who otherwise qualify for and could benefit from these services.

COMMCARE
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Children and Youth Placement Criteria

Inpatient Services (Revenue Code: 124)

<i>Definition of Service</i>	A twenty-four hour protected psychiatric treatment environment, designed for those individuals who are a significant danger to themselves or others, or who are significantly disabled and cannot meet their basic needs and role functions.
<i>Service Components</i>	Physician (psychiatric) services; Nursing services; Medication administration/monitoring; Counseling (individual, family, group); Case management and Discharge planning
<i>Documentation</i>	<i>Psychiatric Evaluation; Physical Examination; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Community Based Alternatives</i>	Crisis Intervention Services; Extended Observation Unit (23-Hour Services); Partial Hospital; Crisis/Respite Care.
<i>Provider Type(s)</i>	Inpatient Psychiatric Facilities shall be JCAHO accredited

Criteria for Certification

Must have a DSM IV Axis I diagnosis.
A child may be appropriate for psychiatric acute inpatient hospitalization if at least one of "B" is present:
A. Lack of therapeutic response.
B. Actual or potential danger to self or others.
1. A danger to self, actively suicidal due to a serious psychiatric disorder.
2. A danger to others, actively homicidal due to a serious psychiatric disorder.
3. Out of control behavior/impulses that seriously impact family and social relationships and/or daily functioning due to a serious psychiatric disorder.
4. Acute psychotic episode in which the individual is responding to the environment in a manner that could place them or others at risk.
The individual requires 24 hour nursing care and physician involvement for the evaluation and treatment process.

Criteria for Certification Change

The individual no longer meets certification criteria or meets criteria for less intensive level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems (Wraparound Services) that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the individual has been developed and explained to the client/guardian.

COMMCARE
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Children and Youth Placement Criteria

Extended Observation Unit (Revenue Code: 762)

<i>Definition of Service</i>	A protected psychiatric treatment environment in which the client can remain for up to 23 hours. This service is designed for those individuals who are in acute emotional distress. The purpose of the modality is to determine whether the distress is related to a transitory situation that is resolved when the individual is provided with structure and treatment interventions.
<i>Service Components</i>	Physician (psychiatric) services; Nursing services; Medication administration/monitoring; Crisis counseling; Case management and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Crisis Intervention Services; Partial Hospital; Crisis/Respite Care.

Provider Type(s)	Inpatient Psychiatric Facilities shall be JCAHO accredited
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
1. The individual verbalizes potential danger to others or self, however verbalization is not related to a serious psychiatric disorder.
2. The individual has a history of out of control behavior/impulses that respond positively to brief removal from situation into structured, safe environment.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems (Wraparound Services) that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

COMMCARE
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Children and Youth Placement Criteria

Crisis Respite Services (Revenue Code: 660)

<i>Definition of Service</i>	Provision of a twenty-four hour living environment with is supportive, structured, clean and safe for individuals who are experiencing a psychiatric crisis.
<i>Service Components</i>	Protective oversight; Access to a QMHP on an on-call basis; Medication administration/monitoring; Crisis counseling; Case management and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Extended Observation Unit; Crisis Intervention Services; Partial Hospital; In-Home Services; Wraparound Services.

Provider Type(s)	Family Treatment Homes; Youth Shelters; Group Homes; Residential Programs
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Criteria for Certification

The individual must have a DSM IV Axis I diagnosis and
1. The individual is not of imminent danger to self or others and The individual is not under the influence of drugs or alcohol.
2. The individual is experiencing a psychiatric crisis that may, without intervention, lead to hospitalization.
3. The individual is in need of continuous oversight and/or medication monitoring and
4. Adequate family/community support is not available within the individual's present environment.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems (<i>Wraparound Services</i>) that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

Note: Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services contractors (CMHC's) may provide and invoice DMH for Respite services provided to seriously emotionally disturbed children and youth who are enrolled in MC+ and who otherwise qualify for and could benefit from these services.

COMMCARE
Community Network for Behavioral Healthcare, Inc.

Children and Youth Placement Criteria

Partial Hospital Services (Revenue Code: 912 Full Day; 910 Half Day)

<i>Definition of Service</i>	A time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. This service is for individuals who are able to remain in the community and present no imminent potential for harm to themselves or others within the structure of a 3 - 6 hours of program per day, (availability 5 days per week.).
<i>Service Components</i>	Psychiatric Services; Nursing Services; Medication administration/monitoring; Counseling; Education services; Case management; Behavior management; and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Crisis Respite Services; In-home Services; Outpatient Services
<i>Provider Type(s)</i>	Inpatient Psychiatric Facilities; Residential Services; Community Mental Health Centers

Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
The individual may be appropriate for psychiatric partial hospitalization if at least one of the following is present:
1. The individual exhibits acute disabling psychiatric symptoms or behavioral problems of sufficient severity to bring about significant or profound impairment in day-to-day education, social and/or interpersonal functioning.
2. The individual has failed to make sufficient clinical gains within an outpatient setting and the severity of symptomatology is such that inpatient hospitalization may be required unless more intensive interventions are provided.
3. Routine nursing and medical observation is required but less than 24 hours a day.
4. The individual's family, guardian or custodian is able and willing to provide the support and monitoring of the individual during non-program hours to ensure adequate behavioral control and to participate in treatment.
5. Suicidal ideation or threat with no intent to harm self. The individual will contract for a "no self harm" agreement.
6. The individual is ready for release from an inpatient setting but is judged to require ongoing intensive therapeutic intervention to make appropriate transition into the community.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems (Wraparound Services) that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

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Children and Youth Placement Criteria

In-Home Services (Revenue Code: 90808 for billing purposes)

<i>Definition of Service</i>	An in-home crisis stabilization service for youth who are at risk of unnecessary out-of-home placement due to an acute psychiatric crisis
<i>Service Components</i>	In-home crisis counseling; Case management; Behavior management; and Discharge planning
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Crisis Respite Services; Partial Hospital Services; Outpatient Services

Provider Type(s)	Residential Providers; Community Mental Health Centers; Licensed Psychologists, Social Workers; Professional Counselors; Bachelor's Level (Case management services only); Child/Adolescent Family Assistance Workers (Behavioral management only)
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis and
1. The individual is at imminent risk of out-of-home placement without therapeutic intervention is provided to stabilize crisis situation and
2. At least one caregiver is willing and able to participate in the treatment process.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or can be managed in a less intensive level of care or
The individual has reached maximum clinical benefit from this level of care or
Support systems (<i>Wraparound Services</i>) that allow the individual to be maintained in a less restrictive treatment environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

Note: Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services contractors (CMHC's) may provide and invoice DMH for CPRP services provided to seriously emotionally disturbed children and youth who are enrolled in MC+ and who otherwise qualify for and could benefit from these services

COMMCARE
Community Network for Behavioral Healthcare, Inc.

Children and Youth Placement Criteria

Outpatient Psychotherapy/Counseling Services

- CPT Codes:** 90804 *Individual Psychotherapy (20-30 Minutes)*
 90805 *Individual Psychotherapy with Medication Evaluation and Management (20-30 Minutes)*
 90806 *Individual Psychotherapy (45-50 Minutes)*
 90807 *Individual Psychotherapy with Medication Evaluation and Management (45-50 Minutes)*
 90853 *Group Therapy*
 90846 *Family Therapy (without Client)*
 90847 *Family Therapy (with Client)*

<i>Definition of Service</i>	Solution-oriented counseling services designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interfere with a client's personal, familial, vocational or community adjustment.
<i>Service Components</i>	Individual; Family; or Group Counseling/Therapy
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Intensive Outpatient Services; Psychoeducational services; Support groups

Provider Type(s)	Psychiatrists; Licensed Psychologists; Licensed Social Workers; Licensed Professional Counselors; QMHP supervised by a Licensed Mental Health Professional
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis.
There are significant symptoms that interfere with the individual's ability to function within one or more life areas.
There is an expectation that the prescribed treatment will show significant progress toward treatment goals within the specified number of sessions.
There is an identifiable stressor associated with the alteration of normal level of functioning.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or
The individual has reached maximum clinical benefit from this level of care or
The client/caregiver is not compliant with the client's <i>Individualized Treatment Plan</i> .

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Children and Youth Placement Criteria

Medication Management (CPT Code: 90862)

<i>Definition of Service</i>	Psychotropic medication adjustment and monitoring services.
<i>Service Components</i>	Prescription for psychotropic medications, review of the effects and side effects, and adjustment of the type and dosage of psychotropic medications prescribed that address the therapeutic goals identified in the <i>Individualized Treatment Plan</i> .
<i>Documentation</i>	<i>Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect treatment plan implementation
<i>Alternative Services</i>	Outpatient Services; Case Management; Psychoeducational Services; Support Groups

Criteria for Certification

The individual has a DSM IV Axis I diagnosis and
The guardian/individual makes an informed choice and agrees to take medication.

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Children and Youth Placement Criteria

Psychiatric Evaluation

CPT Codes: 90801 Psychiatric Diagnostic Interview
90802 Interactive Psychiatric Diagnostic Interview (Child Assessment utilizing play equipment, etc.)

<i>Definition of Service</i>	A diagnostic examination primarily utilized to assess client's need for psychotropic medication or consultation regarding treatment intervention(s) or when the diagnosis is in question.
<i>Service Components</i>	Psychosocial and psychiatric history, mental status and disposition.
<i>Documentation</i>	<i>Evaluation Report</i> , including Axis I - V diagnostic formulation and treatment recommendations.
<i>Alternative Services</i>	<i>Initial Evaluation</i> by a QMHP

Provider Type(s)	Psychiatrist
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Criteria for Certification

1. A licensed clinician or a QMHP has conducted an initial assessment and
2. Individual requires assessment re psychotropic medication or
3. An assessment is required to identify medical condition(s) that may cause psychiatric symptoms or
4. An assessment is required to clarify diagnosis or to provide consultation regarding treatment intervention.

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Children and Youth Placement Criteria

Community Case Management / Service Coordination (CPT Code: 99362) (May be covered by other funding sources)

<i>Definition of Service</i>	Coordination of services to assist clients in maintaining therapeutic gains and progressing toward less intensive services.
<i>Service Components</i>	Coordination and implementation of the <i>Individualized Treatment Plan</i> , including identification of community resources and linkage to services, arranging for or providing appropriate supports to assist the individual in accessing community resources and facilitating communication among all service providers.
<i>Documentation</i>	<i>Progress Notes</i> which clearly reflect treatment plan implementation
<i>Alternative Services</i>	Outpatient Psychotherapy/Counseling Services; Support groups

Provider Type(s)	QMHP; Bachelor's Level under supervision of a QMHP
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Criteria for Certification

1. The individual has a DSM IV Axis I diagnosis.
2. The individual requires access to appropriate services and support to be maintained within the community.
3. The individual has a history of frequent use of highly intensive services or is judged to be at risk.
4. The individual receives services from multiple providers/systems requiring coordination to ensure continuity of care.

Criteria for Certification Change

The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or
The agreed upon termination date has arrived or
Lack of significant progress toward expected goals or
The client/caregiver is not compliant with the client's <i>Individualized Treatment Plan</i> .

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Community Network for Behavioral Healthcare, Inc.

Children and Youth Placement Criteria

Sub-Acute Program (Up to 21 Days) (Revenue Code: 129)

<i>Definition of Service</i>	Provision of a twenty-four hour living environment with is supportive, structured, clean and safe for individuals who are experiencing a psychiatric crisis.
<i>Service Components</i>	Protective oversight; Physician (Psychiatric) services; Counseling (individual, family, group); Medication administration/monitoring; Case management; Education services and Discharge planning. Note: All interventions will focus on reintegration of the individual into the family or alternative living arrangement.
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Crisis Respite Services; Partial Hospital; In-Home Services; Wraparound Services.

<i>Provider Type(s)</i>	Residential Programs
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Criteria for Admission

The individual must have a DSM IV Axis I diagnosis.
1. An individual may be appropriate for sub-acute care if they have an impaired emotional state and impaired social and familial functioning and less intensive modalities have not proven effective.
In addition to the above, the individual must have at least one of the following:
A. Suicidal ideation or threat with no intent to harm self. The individual is willing to contract for a "no self harm agreement".
B. The individual has a recent history of high-risk behaviors.
C. Individual has thoughts of harming others but no specific plan or intent. The individual is willing to contract for "no harm" toward others.
D. The presence of mild acute or moderate worsening of psychotic symptoms such as hallucinations, delusions or paranoia. The individual maintains insight and judgment an is not in any acute danger to self or others.
E. The individual has extremely poor impulse control and difficulty responding to redirection.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or
The individual has reached maximum clinical benefit from this level of care or
Support systems (Wraparound Services) that allow client to be maintained in a less restrictive environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

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Children and Youth Placement Criteria

3-Day Rapid Evaluation (Revenue Code: 918)

<i>Definition of Service</i>	Provision of an in-depth evaluation within a twenty-four hour living environment which is supportive, structured, clean and safe for individuals who are experiencing a psychiatric crisis. The purpose of the in-depth evaluation is to make a differential diagnosis or to recommend treatment interventions.
<i>Service Components</i>	Protective oversight; Physician (Psychiatric) services; Counseling (individual, family, group); Medication administration/monitoring; Case management; and Discharge planning. Note:
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Inpatient Services; Crisis Respite Services;

Provider Type(s)	Residential Programs
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Criteria for Admission

The individual must have a DSM IV Axis I diagnosis.
An individual may be appropriate for a 3-Day Rapid Evaluation if they have an impaired emotional state and impaired social and familial functioning.
In addition to the above, the individual must have at least one of the following:
2. Current suicidal ideation or threat. The individual is willing to contract for a "no self harm agreement".
3. The individual has a recent history of high-risk behaviors.
4. Individual has thoughts of harming others. The individual is willing to contract for "no harm" toward others.
5. The presence of mil acute or moderate worsening of psychotic symptoms such as hallucinations, delusions or paranoia. The individual maintains insight and judgment and is not in any acute danger to self or others.
6. The individual has extremely poor impulse control and difficulty responding to redirection.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or
Support systems (<i>Wraparound Services</i>) that allow client to be maintained in a less restrictive environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

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Children and Youth Placement Criteria

Behavior Management Services (Revenue Code: 662) (May be covered by other funding sources)

Definition of Service	Provision of protective oversight to individuals experiencing an acute crisis related to a psychiatric disorder.
Service Components	Protective oversight; Role modeling/teaching behavioral management techniques for parent/guardian/custodian; Services related to activities of daily living related to the behavioral health needs of the individual. Note: Goal of service is to provide an inpatient alternative during a crisis situation.
Documentation	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
Alternative Services	Inpatient Services; Crisis Respite Services; In-Home Services; Wraparound Services.
Provider Type(s)	A person who has either an associate degree from an accredited community college, a high school diploma or GED; CPR training; and is supervised by a QMHP.

Criteria for Certification

Individual must have a DSM IV Axis I diagnosis and
1. Individual/family is in current crisis situation that requires provision of temporary protective oversight to child in order to diffuse the situation and
2. The family/guardian consents to the provision of service.

Criteria for Certification Change

The individual's condition has deteriorated and the individual meets criteria for a higher level of care or
The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or
The individual has reached maximum clinical benefit from this level of care or
Support systems (<i>Wraparound Services</i>) that allow client to be maintained in a less restrictive environment have been secured and
A follow-up plan for the client has been developed and explained to the client/guardian.

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Community Network for Behavioral Healthcare, Inc.

Children and Youth Placement Criteria

Wraparound Services (CPT Code: 99361) (May be covered by other funding sources)

<i>Definition of Service</i>	Provision of a variety of supportive services, which are required so as to maintain the individual within their home or community setting.
<i>Service Components</i>	Services are flexible and related to the individual's behavioral health needs. Examples may include supervision between school and parent's arrival home from employment; an alarm system for the individual's bedroom window; etc.
<i>Documentation</i>	<i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Behavior Management Services

Provider Type(s)	Flexible
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Criteria for Certification

The individual must have a DSM IV Axis I diagnosis and
1. The individual requires supportive service(s) so as to remain within their own home or community setting and
2. The services must relate to the individual's behavioral health needs.

Criteria for Certification Change

The goals/objectives identified on the client's <i>Individualized Treatment Plan</i> have been accomplished or
The individual has reached maximum clinical benefit from this level of care or

Note: Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services contractors (CMHC's) may provide and invoice DMH for Wrap-Around Services provided to seriously emotionally disturbed children and youth who are enrolled in MC+ and who otherwise qualify for and could benefit from these services

Community Network for Behavioral Healthcare, Inc.

Children and Youth Placement Criteria

Psychological Evaluation (Testing) (CPT Code: 96100)

<i>Definition of Service</i>	Assessment of a client in response to diagnostic or treatment questions.
<i>Service Components</i>	A problem-focused clinical interview and administration/interpretation of standardized tests.
<i>Documentation</i>	A written report which addresses the diagnostic/treatment question and provides treatment recommendations
<i>Alternative Services</i>	Psychiatric Evaluation; Assessment by a Licensed Mental Health Professional

<i>Provider Type(s)</i>	Licensed Psychologist
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<i>Criteria for Certification</i>	<p>Requests for psychological evaluations must be submitted in writing and address the specific diagnostic/treatment question. All requests will be reviewed individually.</p> <p>Note: All requests for educational purposes will be denied. Additionally, requests for Custodial Placement purposes will be denied.</p>
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Children and Youth Placement Criteria

Psychoeducational Groups (CPT Code: 90853)

<i>Definition of Service</i>	Educational groups designed to provide participants with skills to enhance their functioning. Examples include: Stress Management; Anger Control; Problem-Solving; Symptom management (anxiety, depression, etc).
<i>Service Components</i>	Didactic presentation; Group discussion; Handouts (optional); Homework Assignments (Optional)
<i>Documentation</i>	Program curriculum; Participation Log
<i>Alternative Services</i>	Outpatient Psychotherapy; Medication Management

Provider Type(s)	Qualified Mental Health Professional; Bachelor's Level under supervision of a QMHP
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Criteria for Certification

The individual has a DSM IV Axis I diagnosis and
1. The individual presents with mild or moderate symptoms which interfere with their functioning in one or more life area or
2. There is an identifiable stressor associated with the alteration to the individual's normal functioning and
3. The individual has the cognitive capability to learn new skills.

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Children and Youth Placement Criteria

Crisis Intervention (CPT Code: 90899)

<i>Definition of Service</i>	Emergency/crisis behavioral health services that are available 24 hours a day.
<i>Service Components</i>	Services may include evaluation and counseling to stabilize the situation, psychotropic medication stabilization, support services and/or other therapeutic activities to reduce or eliminate the emergency situation.
<i>Documentation</i>	Completion of a <i>Crisis Contact Sheet</i> reflecting intervention(s) and disposition and <i>Risk Assessment Form</i>
<i>Alternative Services</i>	Outpatient Services; Case Management; Psychoeducational Services; Support Groups
Provider Type(s)	Qualified Mental Health Professional (Treatment Interventions); Bachelor's Level under supervision of QMHP (Support Services)

Substance Abuse Services

Note: Individuals are to be referred to CSTAR programs that are managed through the Department of Mental Health, Division of Alcohol and Drug Abuse, unless:

- CSTAR services are not geographically accessible **or**
- The individual chooses **not** to participate in a CSTAR program

Comment:

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Substance Abuse Placement Criteria

Social Setting Detoxification (Revenue Code: 911)

<i>Definition of Service</i>	A process of withdrawing a person from a specific psychoactive substance in a safe and effective manner without the need for ready On-site access to medical and nursing personnel.
<i>Service Components</i>	Observation and supervision by personnel trained to implement physician-approved protocols; Access to appropriate medical services, Education regarding addiction and the detoxification process
<i>Documentation</i>	An addiction-focused <i>Assessment; Individualized Treatment Plan, which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions</i> , designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Medically-Monitored Inpatient Detoxification

Provider Types(s)	DMH certified programs
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Criteria for Certification

The individual has a DSM IV Axis I Substance Abuse Diagnosis
Admission to this level requires that the individual meet one of the following:
1. The individual is experiencing signs and symptoms of withdrawal or there is evidence that withdrawal is imminent.
2. The individual is assessed as not requiring medical supervision A. Vital signs are stable B. Absence of medical complications
3. The individual is assessed as not needing medication but requires this level of service to complete detoxification because of inadequate home supervision or support structure.

Criteria for Referral to Medical Detoxification

The individual has marked lability of vital signs.
Medical complications are present as evidenced by any of the following: <ul style="list-style-type: none"> • Marked change in psychomotor activity • Tremor • Disturbed sleep • Nausea/vomiting • Marked pain or muscle cramps
History of complicated withdrawal episodes such as liver disease, pancreatitis, uncontrollable emesis.

Criteria for Certification Change

Withdrawal signs and symptoms are sufficiently resolved that the individual can be safely managed at a less intensive level of care or
Individual meets criteria for more intensive level of care (medical detoxification) or
Individual meets criteria for admission to psychiatric inpatient admission.

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Substance Abuse Placement Criteria

Intensive Outpatient Services (Revenue Code: 915)

<i>Definition of Service</i>	A structured day or evening program which generally provide nine or more hours per week of structured services consisting of counseling and education around alcohol and other drugs. The individual's need for psychiatric and medical services is addressed through consultation or referral agreements.
<i>Service Components</i>	Educational activities designed to develop and apply recovery skills; Individual/Group Therapy; Case management; and Random drug screening.
<i>Documentation</i>	An addiction-focused <i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> which clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Social Setting Detoxification; Medically Monitored Inpatient Detoxification

Provider Types(s)	DMH certified programs
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Criteria for Certification

The individual has a DSM IV Axis I Substance Abuse Diagnosis
1. The individual does not require detoxification.
2. Biomedical problems, if any, are stable and do not require availability of medical/nursing monitoring and
3. The individual's mental status, including emotional stability and cognitive functioning, is assessed as sufficiently stable and adequate to permit participation in the therapeutic interventions.

Criteria for Certification Change

The goals/objectives identified on the individual's <i>Individualized Treatment Plan</i> have been accomplished or
Individual meets criteria for more/less restrictive level of care and
A follow-up plan has been developed and explained to the individual/guardian.

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Substance Abuse Placement Criteria

Outpatient Services

CPT Codes: 90804 *Individual Psychotherapy (20-30 Minutes)*
 90806 *Individual Psychotherapy (45-50 Minutes)*
 90853 *Group Therapy*
 90853 *Psychoeducational Group*
 90846 *Family Therapy (without Client)*
 90847 *Family Therapy (with Client)*

<i>Definition of Service</i>	Addiction recovery services designed to address lifestyle, attitudinal and behavioral issues that have the potential to inhibit the individual's ability to cope without the use of alcohol or other drugs.
<i>Service Components</i>	Educational activities designed to develop and apply recovery skills; Individual/Group Therapy; Random drug screening.
<i>Documentation</i>	An addiction-focused <i>Assessment; Individualized Treatment Plan</i> which includes problem formulation, treatment goals and measurable treatment objectives, as well as interventions designed to meet these objectives; <i>Progress Notes</i> that clearly reflect implementation of the treatment plan, the client's response to treatment and consequent amendments to the plan.
<i>Alternative Services</i>	Social Setting Detoxification; Intensive Outpatient Program

Provider Types(s)	DMH certified programs
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Criteria for Certification

The individual has a DSM IV Axis I Substance Abuse Diagnosis and
The individual does not require detoxification and
Biomedical problems, if any, are stable and do not require availability of medical/nursing monitoring and
The individual is functioning adequately in life task areas of work/school, social functioning and primary relationships and
The individual's social system is supportive of recovery to an extent that the individual can adhere to a self-directed treatment plan without substantial risk of relapse/continued use and
The individual's mental status, including emotional stability and cognitive functioning, is assessed as sufficiently stable and adequate to permit participation in the therapeutic interventions.

Criteria for Certification Change

The goals/objectives identified on the individual's <i>Individualized Treatment Plan</i> have been accomplished or
Individual meets criteria for more/less restrictive level of care and
A follow-up plan has been developed and explained to the individual/guardian.