

Department of Health and Human Services
Children's Behavioral Health Services



Provider Manual for:

MaineCare Sections 65 M&N

**Child and Family Behavioral Health Treatment
(Section 65 M)**

**Community Based Treatment for Children Without Permanency
(Section 65 N)**

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**Information in this Manual Applies to Both Section M&N Services,
Except Where Specifically Noted**

Note: This manual will be revised from time to time with the benefit of experience of implementation and with improvements in the operation of 65M/N services. CBHS will make revisions in the manual as appropriate, in response to feedback from CBHS staff, OCFS staff, providers, members and family members.

Acronyms

| | |
|---------------|---|
| BCA | Beacon Clinical Advisor |
| BHP | Behavioral Health Professional |
| CAFAS | Child and Adolescent Functional Assessment Scale |
| CBHS (65H) | Children's Behavioral Health Services, DHHS |
| CBTCWPS (65N) | Community Based Treatment for Children Without Permanency Service |
| CEF | Central Enrollment Form |
| CFBHTS (65M) | Child & Family Behavioral Health Treatment Service |
| CGAS | Children's Global Assessment Scale |
| DHHS | Department of Health and Human Services |
| DOC | Department of Corrections |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| ITP | Individual Treatment Plan |
| LCD | Last Covered Day of Service |
| OCFS | Office of Child and Family Services |
| PA | Prior Authorization |
| PECFAS | Pre-School and Early Childhood Functional Assessment Scale |
| SED | Serious Emotional Disturbance |
| UR | Utilization Review |

Definitions:

See the MaineCare Benefits Manual Ch II, Section 65 Definitions

Beacon Clinical Advisor: Beacon Clinical Advisors are independently licensed clinicians contracted by DHHS to conduct the review of members applying for 65 M/N treatment services and review these members for: level of care determination, initial authorization, and re-authorization determinations. They serve as agents of DHHS for this purpose. They will comply with all state and federal regulations, laws, and Departmental policies, including all federal and state laws regarding confidentiality of records.

Child and Adolescent Functional Assessment Scale (CAFAS): The CAFAS (Hodges, K. 1977) is a standardized assessment tool that has been demonstrated to be statistically valid and reliable. CAFAS is designed to measure the degree of functional challenges in children and adolescents ages 6-20 with emotional, behavioral, and/or substance abuse problems. The instrument contains eight subscales, including: 1) School/work, 2) Home, 3) Community, 4) Behavior towards others, 5) Moods and Emotions 6) Self Harmful Behaviors, 7) Substance

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Abuse, and 8) Thinking. Ratings on each subscale are determined based on the rater knowledge and understanding of the member/member's behaviors over a 90-day period.

The CAFAS is completed by the designated service provider, based on their knowledge of and experience with the child/family situation. The CAFAS is completed by the service provider after the necessary information has been obtained from the member and family and other informants. The CAFAS was not designed to be used as a diagnostic interview tool, and should not be administered in this way. Only individuals who have been trained and have met the established CAFAS rater reliability criteria are permitted to use these tools.

Child and Family Behavioral Health Treatment (CFBHT): Section 65M

Community Based Treatment for Children Without Permanency (CBTCWP): Section 65N:

These are time limited, multidisciplinary, multimodal treatment programs that are provided in a home or community settings, (typically 2-3 hours per day, 2 to 3 times per week, for 1-6 consecutive months). Frequency and intensity of treatment are individualized and based on the clinical needs of each child and/or family in the service.

This level of care is used to intervene in complex clinical situations through treating the member only (65N) or treating the member with his/her family system (65M). In both treatment services counseling and behavioral interventions will be employed directed towards achieving improved member and family functioning, where appropriate.

These programs are for members with serious emotional disorders (SED – definitions) (both 65M&N) and their families (65M only). This is for members for whom other less intensive levels of service (e.g. traditional outpatient services) have not been effective or are extremely unlikely to be effective.

These are mental health treatment services that are part of the continuum of care.

Children's Global Assessment Scale (CGAS): 100 point rating scale measuring psychological, social, and school functioning for members aged 6-17. It was adapted from the Adult Global Assessment Scale and is a valid and reliable tool for rating a child's general level of functioning.

Continuum of Care: CFBHTS and CBTCWPS are part of a continuum of mental health treatment services. A continuum of care includes a range of publicly funded treatment services or programs that are tailored to meet the needs of consumers, from most intensive (psychiatric hospitalization) to least intensive (respite services). A continuum of care implies there is a linkage and coordination as the member moves from one level on the continuum to another, as their needs change.

Levels of care lower on the continuum than CFBHTS and CBTCWPS include office based outpatient treatment, typically including individual, family, or group treatment, psychiatric evaluations and medication treatments. Office based treatments are usually delivered weekly or less often. Other lower levels of care include respite care, case management, and support groups. Levels of care that are higher on the continuum of care than CFBHTS or CBTCWPS are staffed by a multidisciplinary team, usually for several hours/day or more and at least several days a

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week. The team typically includes psychiatrists, psychologists, therapists, case managers and at times occupational and physical therapists. Examples of this higher level of care include Assertive Community Treatment teams (ACT), Partial Hospitalization or Intensive Outpatient Programs. More intensive levels of care include residential and inpatient services. In these settings members receive 24 hours/day supervision during which the treatment is provided at the level of intensity required by the individual to regain a level of stability and functioning necessary to continue with lower levels of care.

Failure to Benefit from Treatment: Is a situation in which the member and family continue to have the same identified mental health problems, of the same or higher frequency, intensity and duration as they did on admission to a program, after having engaged in an adequate trial of treatment.

Last Covered Day: The last day that an authorization to provide and bill for services is in effect. If the provider has not obtained a new authorization after the Last Covered Day, the provider is not authorized to be reimbursed for service provision.

Medically Necessary Health Care means health care treatment provided to a member for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of the illness, injury, or disease in a manner that is:

- A) Consistent with generally accepted standards of medical practice;
- B) Clinically appropriate in terms of type, frequency, extent, site, and duration;
- C) Demonstrated through scientific evidence to be effective in improving health outcomes;
- D) Representative of “best practices” in the medical profession; and
- E) Not primarily for the convenience of the member, or physician, or other health care practitioner.

For the purposes of this service, “Medical Necessity” is defined by the eligibility criteria listed in the MaineCare Benefits Manual Ch II Section 65M & 65N.

Pre-School and Early Childhood Functional Assessment Scale (PECFAS): The PECFAS (Hodges, K. 1990) is a standardized assessment tool that is designed to measure the degree of functional challenges in children ages 2-5 with emotional, behavioral problems. This tool has been found to be statistically valid and reliable. The instrument contains seven subscales, including: 1) School/Daycare, 2) Home, 3) Community, 4) Behavior towards others, 5) Moods and Emotions 6) Self Harmful Behavior, and 8) Thinking/Communication. Ratings on each subscale are determined based on the rater knowledge and understanding of the child’s behaviors over a 90-day period.

The PECFAS is completed by the designated service provider, based on their knowledge of and experience with the child/family situation. The PECFAS was not designed to be used as a diagnostic interview tool, and should not be administered in this way. Only individuals who have been trained and have met the established PECFAS reliability criteria are permitted to use these tools.

Prior Authorization (PA) is a review of the member’s proposed Individual Treatment Plan (ITP) goals, CAFAS or PECFAS, C-GAS scores, and clinical assessment material before

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treatment is authorized. The purpose of the review is to determine the appropriate level of clinical care, to ensure that the clinical care provided to a member is medically necessary, as defined in §4301-A (10-A), 24-A M.R.S.A and is consistent with best practice standards. Prior authorization assesses whether the proposed treatment best meets the needs of the member, is within the standards of practice, and that discharge criteria and planning are initiated at time of admission. Prior authorization is conducted by Beacon Clinical Advisors (BCA) in partnership with CBHS UR Staff.

Transition Period: The 90 day time period for transitioning from Section G/H services to Section M/N services or other services that are appropriate. This period begins on the first day that the new Sections 65M/N policies become MaineCare approved final rules, and ends on the 90th calendar day from that date.

Uncovered Days of Service: Days of service provided for which there was no authorization and will not be reimbursed by DHHS or MaineCare.

Utilization Review (UR): Utilization review is the process of determining whether all aspects of a member's care, at every level, are medically necessary and appropriately delivered. UR is conducted through a collaborative relationship by Beacon Clinical Advisors and CBHS UR staff.

Utilization Management: The process of incorporating the strategies of cost containment, appropriate utilization of services and case management in a cooperative effort with other parties to address the issues of access to quality healthcare services at an affordable cost.

A. Introduction:

Children's Behavioral Health Services (CBHS) of the Maine Department of Health and Human Services has developed the **Child and Family Behavioral Health Treatment Service (CFBHTS)** and **Community Based Treatment for Children Without Permanency Service (CBTCWPS)** as intensive in-home/community-based treatment services for children/youth and their families, when appropriate, in need of comprehensive, clinical, home and community based mental health treatment services. CFBHTS and CBTCWPS are part of a continuum of mental health treatment services and are benefits that are reimbursable by MaineCare. These programs are for members who have **serious emotional disorders (SED)**.

The goal of these programs is to provide treatment with the member and family, when appropriate of sufficient breadth and intensity that the member can maximize his/her development in his/her home and community. This program will be managed through the use of **prior authorization (PA)** and **utilization review (UR)**.

This manual describes the policies and procedures of CFBHTS and CBTCWPS as MaineCare services. This manual contains detail on the completion of: The Central Enrollment Referral, Assessment Authorization, Treatment Authorization requests, UR and Treatment Re-Authorization requests, and Discharge requirements. This manual was developed in order to clarify and facilitate the authorization process. The manual will be revised and expanded from

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time to time to reflect the experience of providers and CBHS staff in the initial implementation phases of the PA/UR of this new service.

A.1 Rationale:

Research shows that when treatment is provided in isolation of the child's normative environment, there is little generalization of positive treatment outcomes back to the child's home and community. A high level of parental involvement with clinical therapy conducted in home and community settings are key to successful generalization of positive treatment outcomes. Treatment services in Maine for this population have relied heavily on "out-of-home" treatment, service in the home without parental participation (65H and sometimes 65G), or service with minimal home-based clinical involvement (65H and often 65G). In circumstances where traditional out-patient treatment is insufficient to meet member need, CBHS must provide a higher level of service on the **continuum of care** of treatment. This treatment requires:

1. The treatment is to be **community and home based** with the treatment provided in the member's and/or the member and family's natural environment, so that skills can be learned and integrated in the environment where they will be used.
2. **Active parent/caregiver participation.** Parent/Caregiver involvement is essential to successful treatment. Therefore parents will need to be involved in all aspects of the treatment strength and problem definition, designing intervention and skill building programs, assessing outcomes, and refining treatment plans as treatment proceeds. Parents, their child, and the treatment team will work collaboratively throughout this process. Parent/Caregiver involvement is required for 65M services; it is optimal, though not required for 65N services.
3. **Increased Frequency of clinical and counseling service** (as compared with outpatient treatment): This program will typically consist of 2-10 hours/week for 3-6 months vs. current 1-2 hours/week for an average of 2-3 months.
4. **Staff qualifications of the clinician and behavioral health professional** will be sufficient to meet the treatment needs and complexities that members with serious emotional disturbance present. This means that as there is an increase in the member's treatment needs and their complexity, the clinician will be increasingly involved in the member and family's care.
5. Provision of **treatment by a clinical team** that includes at least one licensed clinician on each team and one certified behavioral health professional (BHP).

A.2 Method:

CFBHTS and CBTCWPS will provide an intensive community based treatment service, within a larger system of care, which is individualized to meet the treatment needs of members with SED and their families. This focus requires that the treatment address the member's treatment needs in the context of his/her environment. The individual treatment plan will describe the clinical combination of intensive work with the member, family and/or primary caregivers, and will support the member's and family's ability to identify and utilize natural and community supports (e.g. neighbors, extended family, school, "Y", sports, church, etc). The CFBHTS and CBTCWPS will work closely with the member's case manager, if there is one involved.

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Case Managers, other providers, community, and family members, or CBHS staff refer a member to these services by submitting a Central Enrollment Referral Packet (Appendix) to the Regional CBHS Central Enrollment staff. CBHS staff and the **Beacon Clinical Advisor (BCA)** will review the available information and determine whether or not 65M/N is the appropriate treatment for this member and family. If they have any questions they may request additional information from the referral source. If they determine 65M/N is an appropriate clinical service and level of care for this member and family or member, the member will be found eligible for the service. CBHS will then follow the member through the central enrollment process, until there is a provider with availability to assess and treat the member and family. At that time, CBHS Central Enrollment staff will match the member with a provider.

The provider will be authorized to perform an assessment, and to develop a treatment plan. They will have 8 billable hours over a 30 day period to conduct an assessment with their treatment team, and submit a Treatment Authorization request to the regional BCA. Providers are encouraged to engage with the member and family quickly to begin the assessment period as soon as possible. The BCA will use clinical and assessment information submitted by the community provider to authorize the number of hours and length of service requested. The number of hours of service and the percentage of time the clinician spends with the member and family will depend on the treatment needs of the member. Treatment authorizations will be for up to 90 days. It is expected that treatment duration will typically be 3-6 months. Treatment beyond 6 months will require authorization by the CBHS Medical Director (or designee), and will only be authorized if clinical review indicates substantial progress using this treatment service.

. CBHS will work collaboratively with CFBHTS and CBTCWPS providers to address the treatment needs of the member and family (65M) or member alone (65N).

Further treatment may be necessary for the member and family, either at a higher or lower level of service. Transition to other services should be planned well in advance of the completion of CFBHTS or CBTCWPS.

A.3 Eligibility: Please see the MaineCare Benefits Manual Ch II Section 65M & 65N

B. Standards of Operation of 65M/N Treatment Teams:

B.1 CFBHTS and CBTCWPS Standard of Care:

1. As part of the UR process, providers must describe how they will allocate services more intensively over a shorter period of time (than current in home support programs); and manage their caseload to transition the member and families to less intensive levels of service or other natural community supports. Details of the process are described beginning on page 13 of this manual.
2. CBHS strongly encourages Evidence Based or Best Practice Models of care such as but not limited to: Multi-systemic Therapy (Scott Henggeler), Intensive In-Home Child & Adolescent Psychiatric Service (Joe Woolston – Yale), or Intensive Home Based Service (Providence), Functional Family Therapy (University of Arizona).

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Staffing - Providers are required to have the clinical expertise and support to provide the CFBHTS and CBTCWPS to members and families in acute crisis, and to members and families with multiple stresses such as poverty, out of home placement, acute and chronic medical illness, psychiatric hospitalization, recent losses, active substance abuse, the presence of a mental illness in a parent, or the risk of homelessness. The treatment team will include one **clinician** and one **Behavioral Health Professional (BHP)**. Alteration in staffing patterns from the proposed team may be considered in the following circumstances, if they are authorized by the Director or Medical Director of Children's Behavioral Health Services:

1) The provider is using a model that is evidence based for the specific needs of the child,
or

2) There are extraordinary circumstances that require additional staffing.

Rationale for alternative staffing patterns must first be submitted to the Beacon Clinical Advisor.

3. The admission criteria for CFBHTS and CBTCWPS are clearly stated in the MaineCare Benefits Manual CH II, Section 65.
4. The provider team must begin treatment as soon as possible but no later than 10 working days after the authorization for services.
5. Availability of psychiatric consultation: Please see the MaineCare Benefits Manual CH II, Section 65M & 65N.

B.2 Provider Certification: Providers must be an approved MaineCare provider in good standing and must meet DHHS licensing and contract requirements.

B.3 Family Involvement – CFBHTS (65M) is a strengths based and systemic program whose success depends on active family involvement in defining the problem, establishing realistic treatment goals, designing tools to assess progress, implementing the treatment plan, refining the interventions and assessing their outcome yet again. In this program families will be empowered and supported in taking an active role in meeting the treatment needs of their child. It is expected that they will actively participate in some portion of all counseling and treatment sessions. The provider is expected to utilize the family's strengths in each aspect of the treatment plan, and to provide the intensive treatment in the home, that facilitates the family's acquisition of strengths and skills to address the behavioral issues that required this level of treatment.

CBTCWPS (65N) is also a strengths based and systemic program. Providers of this service should make every effort to involve families in the treatment, as described above. Family participation in treatment is optimal and desired. However, given the population this service is designed for, family involvement may not be possible, and is not required.

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B.4 Missed Appointment Policy: Provider agencies must make a concerted effort to connect with the member and family. These attempts must be documented. If the family cancels or does not keep 3 consecutive appointments, the provider may choose to discharge the member/family from the service.

If the family misses appointments during the course of authorized treatment, the team must make a concerted effort to identify and address the reasons for the missed appointments. If the member and family miss more than 25% of their appointments, the provider may discharge the member/family from the service.

B.5 Other Standards of Care

1. CBHS embraces Systems of Care Principle (see Appendix) and operates CFBHTS and CBTCWPS as part of a System of Care for members and families.
2. Providers are encouraged to customize the levels of intervention to the member/families' progress through CFBHTS and CBTCWPS – moving them to lower levels as they make progress in their recovery and in management of their child's behavior.
3. Applying Principles of Utilization Management to CFBHTS and CBTCWPS: Each provider will work with CBHS staff to actively review the treatment of the members and families they are working with, to identify, monitor, and assess member and family strengths as key components to the CFBHTS and CBTCWPS interventions. Through this process, timely and appropriate services will be provided allowing members and families to progress through service levels into less restrictive treatments and community services.
4. Managing the Provision of Service
The provider will be authorized to provide a certain number of hours of service, over a specified length of time. For each member receiving service, the provider is responsible for managing:
 - a. The # of hours of staff time used each week;
 - b. The weekly average of hours used over the authorized period;
 - c. The ratio of time used each week between the clinician and the BHP.

The beginning of treatment may require:

- a. More hours of service in the week
- b. A higher ratio of clinician time to BHP time.

As progress occurs, the provider will decrease both the hours per week, and the percentage of clinician time, as appropriate.

Example: after the authorized assessment is completed and the ITP done, the provider is authorized to provide 130 hours of service in the first 90 day period (almost 13 weeks). The estimated number of hours of service per week is 10. The estimated number of hours per week for the clinician is 4 and the BHP is 6.

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At the time of Treatment re-authorization, the provider is authorized for 57 hours of service, avg. 4.4 hours per week, estimated 2 hours for the clinician and 2.4 for the BHP. It is expected that based on the member/family level of need and the course of treatment, the provider will manage their utilization in the following way:

Using the above example:

a. Authorized Period of Treatment:

- i. 1st Month: 15 hours per week avg, 6 hours clinician, 9 hours BHP
- ii. 2nd Month: 10 hours per week avg, 4 hours clinician, 6 hours BHP
- iii. 3rd Month: 5 hours per week avg, 2 hours clinician, 3 hours BHP

b. Re-Authorized Period of Treatment:

- i. 4th Month: 5 hours per week avg, 2 hours clinician, 3 hours BHP
- ii. 5th Month: 5 hours per week avg, 2 hours clinician, 3 hours BHP
- iii. 6th Month: 3 hours per week avg, 1 hour clinician, 2 hours BHP

5. Use of Outside Consultation by Providers: Additionally Utilization Management, in some cases, should focus on the need for additional resources or use of more intensive interventions. In these cases, the Department encourages the 65M/N provider to seek additional clinical expertise within or outside their agency to assist the team in reviewing the current treatment plan. Such consultation is not a billable activity in this service. Beacon and CBHS staff is available to assist providers in developing the best practice interventions for members and their families.
6. CBHS and Provider Case Reviews etc.: CBHS seeks to develop and continue working clinical/administrative partnerships with CFBHTS and CBTCWPS community providers in the management and operation of the services, as the treatment service relates to: individual case reviews; identification of treatment planning for unusual cases and review of aggregate program data.
7. HIPAA: CFBHTS and CBTCWPS providers will comply with all HIPAA standards.
8. MaineCare: This CBHS program will operate within all existing DHHS MaineCare regulations.
9. Collaboration: Providers of CFBHTS and CBTCWPS shall collaborate with other government departments (for example DOE, DOC) wherever indicated. The provider, with the case manager (if there is a case manager working with the member/family) , will ensure that all partners (e.g. school, primary care physician, etc) in the system of care, are working together in a unified fashion, with the member and family (65M) or member alone (65N).

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C. Central Enrollment/Utilization Review (CE/UR) Process:

C.1 Members currently receiving 65 G or H or on 65 G or H waiting lists: see Appendix 6

C.2 For members newly referred to this service:

1. Providers Notify Regional CBHS Office of Capacity
 - a. No less than weekly, 65M/N providers will provide to the Regional CBHS office staff, information regarding capacity that they have to accept new referrals into their program.
 - b. **Region I:** Report each Tues. to Mike Parker via email Mike.parker@maine.gov or phone 822-0139
 - c. **Region II:** Report each week to Suzanne Boras via email: suzanne.boras@maine.gov
 - d. **Region III:** Report each Tues. to Gary Kaszas via email gary.kaszas@maine.gov and cc to ed.kowalzyk@maine.gov
 - e. Key Aspects About Reporting Capacity:
 - i. Report at least weekly, even when no capacity for that week
 - ii. Report by email preferred
 - iii. Report number of openings
 - iv. Report staff characteristics needed to make a good match:
 - v. Towns/counties they can serve in, skill level, special skills or training, gender, age, exceptions to hours of availability
 - vi. Get to know your regional contact person to enhance communication
2. Central Enrollment Referral
 - a. A Referral Source for 65M/N will typically be a Targeted Case Manager. Referrals can come from any source, including parents, pediatricians, Child Welfare Services case workers, Juvenile Community Correction Officers, CDS, crisis programs, local schools etc. All referrals must have the specific permission of the legal guardian.
 - b. The referral source faxes a Central Enrollment (CE) Referral Packet to the Children's Behavioral Health Services (CBHS) Regional office, Central Enrollment staff person. This packet includes a Children's Enrollment Form, the DHHS Referral Form for 65M/N, and the member's most current diagnostic evaluation or assessment.
 - c. CBHS Regional Central Enrollment staff will verify that the member is enrolled in Maine Care and ensure that the CE Referral Packet is complete. If the referral is incomplete, the referral packet will be returned to the referent for completion. If the completed referral is not re-submitted to CBHS within 5 days, CBHS will consider the referral to be withdrawn.
 - d. The CE Referral Packet will be forwarded to the regional Beacon Clinical Advisor (BCA) to determine the Level of Care (LOC). BCA has two days to make the LOC determination or request additional information from the referral source.
 - e. A letter will be sent to the referral source and the family informing them of the eligibility and LOC determination.
 - f. The member's name will be placed on the Central Enrollment capacity list for 65M&N services.

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- g. A member will be assigned to an agency consistent with the terms of the Risinger settlement agreement with capacity based primarily on the number of days that the member has been waiting for service, with consideration for geographic location, age, gender, and presenting problems.
3. Perform Authorized Assessment
- a. At the time that a member is assigned to an agency, BCA will authorize up to 8 hours for the 65M&N provider agency to conduct an assessment and develop a treatment plan. The CBHS staff will fax the CE Referral Packet and assessment authorization to the 65M & N provider.
 - b. CBHS Regional Central Enrollment staff will notify by letter, the member/guardian and the referral source that the member has been matched to a provider and that the provider has been authorized to conduct an assessment.
 - c. The authorized assessment period is 30 days.
 - d. The assessment and the treatment plan must be completed within 30 days of the assessment authorization date.
 - e. During the authorized assessment period, the provider is responsible for addressing the clinical needs of the member and his/her family, and to provide a level of services, including targeted clinical interventions as needed. If additional authorized assessment time or hours are needed as a result, the provider should contact the BCA for an additional authorization.
 - f. The assessment will include a full bio-psycho-social assessment with diagnosis (DSM or DC 0-3), a CAFAS (or PECFAS) and a CGAS score.
4. Treatment Authorization
- a. After completing the assessment, 65M&N providers submit a Treatment Authorization Packet by fax to the Regional BCA. The packet is due no later than 30 days after the assessment authorization date. This packet includes the provider's completed assessment, a current CAFAS (or PECFAS), and CGAS score, and a Treatment Authorization Request Form. On that form (along with other information), the provider reports the length of service, and number of hours of service, that they propose will best meet member need. The provider and the BCA may negotiate the proposed number of hours. Of the total requested, the provider will estimate the number of hours to be used weekly and an estimate of the number of hours that will be used by the clinician, and the number of hours that will be used by the BHP. It is understood that the ratio of hours between clinician and BHP will vary, according to member need.
 - b. On the Treatment Authorization Request form, a provider may request that the start date of the authorized service coincides with their first appointment after the Authorized Assessment Period ends. If a provider is concerned that they won't receive the Treatment Authorization before their next appointment, they may note on the Treatment Authorization form that they need an expedited Authorization due to a pending appointment, or they may call the Beacon Clinical Advisor to request same.
 - c. If it is determined by the Regional BCA that the service is appropriate, then authorization for treatment will be given. This authorization can be for a period of up to 90 days..
 - d. The Department asks that while planning the hours of service needed for treatment with a member and family (65M) or member (65N), the provider explains that any planned

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hours are provisional until they are reviewed and negotiated with the Beacon Clinical Advisor.

- e. The 65M&N provider agency, referral source and the legal guardian will receive written notification of authorization for service by mail or fax. The Department will ensure that authorization notification is conducted in a manner intended to avoid delays in treatment.
- f. The 65M&N provider agency will send a Change of Status form to the CBHS Central Enrollment regional staff to remove the member from the 65M&N wait list within five day of beginning treatment.

5. Treatment Re-Authorization

- a. If the legal guardian and the provider determine that the treatment needs will continue beyond the original authorization period, the 65M&N provider must send a request for re-authorization to the regional BCA for continued treatment. The Treatment Re-Authorization Packet includes a DHHS Treatment Re-authorization Request Form, an updated CAFAS (or PECFAS) and an updated CGAS score. This packet must be submitted to the regional BCA **at least** 5 days prior to the last covered day (LCD) of the original authorization.
- b. As with Treatment Authorization, the provider requests re-authorization in writing, and can negotiate the hours of service, with the BCA. This request is made on the Treatment Re-Authorization Request Form.
- c. If it is determined by the regional BCA that continued treatment is appropriate, the re-authorization will be given. This re-authorization can be for a period no longer than 90 days from the date re-authorization.
- d. The 65M&N provider agency, referral source and the legal guardian will receive written notification of re-authorization for service by mail or fax.

6. Inactive Status

- a. A provider may place a member on inactive status for up to 30 days at their discretion. To maintain a member on inactive status beyond 30 days, the clinician must make a request to the Beacon Clinical Advisor for an extension of the inactive status. The request must include the rationale for the extension, and the anticipated date that service will start again. There is no form required for this process.

7. Discharge

- a. Upon completion/ending of treatment, the 65 M& N provider will submit a Discharge Packet to the regional BCA. The Discharge Packet is due no later than 5 days after the end of service. This Discharge Packet includes a DHHS Discharge Form, a Change of Status Form, an updated CAFAS (or PECFAS) and an updated CGAS score. The 65M&N provider will notify the referral source of the ending of service.

8. When More than One Child in a Family is Referred for Service: When more than one child in a family is referred for service, the team shall work with the parents and children to address the individual and family needs. No more than one team shall be involved with a family at one time.

9. Authorization Beyond the Initial 6 Month Period

- a. If the legal guardian and provider assess that treatment should continue beyond 6 months, the provider must submit an Exception Request Packet to the Regional BCA. This packet is due **at least** 5 days prior to the Last Covered day (LCD) of service. The request will be reviewed by the Medical Director (or designee), who will make a determination

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regarding continued authorization. The Extension Request Packet includes a Re-authorization Form, an updated CAFAS (or PECFAS), an updated CGAS score, and an explanation by the 65M&N provider supporting why this level of care requires continuation beyond 6 months. The explanation must include the following:

- i. What specific behaviors continue to put the member and/or their family at risk?
- ii. What has been the measurable effect of the 65M/N service to date?
- iii. What is the plan to address the behaviors, and how will the behaviors be measured?
- iv. How is this different from the current treatment plan?
- v. Describe the roles of 65M/N staff, family and other involved parties.
- vi. What other services are being provided?
- vii. What interventions have not worked?

CBHS will give special consideration to extensions for priority populations: Members at imminent risk of hospitalization or other out of home treatment, members involved with Child Welfare Services, and members with one or more parent with mental illness, mental retardation, traumatic brain injury or other disability.

Central Enrollment Contacts:

Region I (Districts 1 and 2): Central Enrollment Contact: Jana Colby @ 822-0134 (Cumberland County). Brenda Smith @490-4606 (York County)

Region II (Districts 3, 4, 5): Central Enrollment Contact: Lynn Dorso @ 287-6203 or Jeanne Tondreau @ 287-8499

Region III (Districts 6, 7, 8): Central Enrollment Contact: Gary Kaszas @ 554-2125

D. Criteria for Treatment Authorization

CBHS or its designees will apply the admission criteria delineated in the CFBHTS and CBTCWPS Eligibility Criteria (MaineCare Benefits Manual CH II Section 65). These criteria include: a diagnosis that meets the criteria for severe emotional disturbance (SED), CGAS and CAFAS (or PECFAS) scores typically in the SED range (see appendices 4&5). In addition, for CFBHTS, a consideration of the family's willingness and capacity to participate with the service, and for CBTCWPS consideration of the member/member's willingness and capacity to participate are also considered. Finally, a clear statement of the problem behaviors, with measurable time limited goals for the service intervention is needed. While the CGAS and CAFAS scores will be an important guide to the level of care required, Beacon and CBHS UR staff along with the treatment team will consider the family's or member's capacity to accept intensive services. In some cases the clinical picture may indicate a higher level of service than is being requested, but the level is appropriate when considering the families or member's overall functioning. In other cases, the member's functioning may be lower than the level requested, but the family may not be ready to accept the level of intensity indicated by the score at the time of request.

As part of the authorization and service delivery, CBHS expects the provider to establish a strength-based treatment plan with time frames for completion of treatment goals. For CFBHTS,

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there will be evidence that the family has participated in developing the goals and has also participated in the assessment of achieving these goals.

In reviewing treatment authorization and re-authorization requests, the BCA will look for specific measurable progress that the member and family (65M) have made based on the interventions. Consideration will be made for new goals which can be completed within the designated time frame. While CBHS is aware that many families and member have multiple problems that may persist, it is expected that the treatment planning and review process include plans to transition the member and family to less restrictive treatment and natural supports available in the community (e.g. outpatient individual and family mental health, or sports, church member groups, theater clubs, etc.)

The provider is expected to adapt the interventions to the family and member's changing and emerging needs. The treatment plan may be modified or amended to reflect progress made in treatment, with new goals and objectives.

E. Disagreement on Authorization

In cases where the BCA and the provider disagree on the nature of the request or where there are questions about the level of the service and/or length of time that has been requested to address the member's and family's needs, the BCA and the 65M/N provider have several options:

1. The BCA may determine that more information is needed to support the request, and the authorization decision will be deferred for up to two working days to allow the provider to gather more information.
2. The BCA may approve the request as is, and authorize less than 90 days of treatment.
3. The BCA and the provider may mutually agree to modify the provider's request, by either changing the length of the request, or the hours approved. The provider will receive an authorization letter from CBHS that reflects the modified terms for that member and family.
4. The BCA may deny the request and offer the member and family the right to appeal the decision per the process described on the Office of Administrative Hearings Website, <http://www.maine.gov/dhhs/adminhearings.htm>

It is important for providers and member/families, while planning the hours of service needed for treatment to keep in mind that any planned hours are provisional until they are reviewed and negotiated with the Beacon Clinical Advisor.

The BCA will FAX the approved, modified, or denied information to the provider. The legal guardian and case manager will receive copies of the authorization. Due process information will be included where indicated.

F. Quality Assurance and Network Management:

1. Review of Aggregate Program Data.

CBHS will work with its providers to develop and operate services based on encounter data and outcome measures. The new CFBHTS and CBTCWPS programs will provide a unique

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opportunity to use data for purposes of clinical decision making, program assessment, and policy development. CBHS will develop provider profile reports that will be shared with providers as part of the Quality Assurance and Quality Improvement process.

2. Network Management

The CBHS Team will include Beacon Clinical Advisor Staff, the CBHS UR Nurses in each Region, designated CBHS staff, the Beacon Clinical Director, and CBHS Medical Director.

The day-to-day operation of the clinical review and authorizations is the responsibility of the Beacon Clinical Advisor Staff and the Beacon Clinical Director. They will consult with the CBHS UR nursing staff regarding any clinical questions or possible denials.

The responsibility for maintaining working relationships with CFBHTS and CBTCWPS providers will be shared by Beacon staff, and CBHS UR nursing staff. Other Regional CBHS staff will be involved as indicated and recommended by the Regional Team Leaders, in consultation with the Medical Director and Systems Manager for CBHS.

3. Review of Critical Incidents: This will follow current DHHS policy and practice.

4. Due Process:

A letter describing due process is sent to the legal guardian or member (65N) with each notification of treatment start, authorization, or denial.

The member (65N) or family (65M) have appeal rights as spelled out on the Office of Administrative Hearings Website, <http://www.maine.gov/dhhs/adminhearings.htm>, when the treatment services they apply for are denied, decreased, or terminated.

Family and member complaints and grievances: Providers will inform families and/or members of their agency-specific complaint and grievance process and keep track of complaints to report to CBHS on a quarterly basis, as outlined in the current contractual obligations.

G. Billing Considerations:

1. Eligibility – CBHS is responsible for determining eligibility for all 65M/N members.
2. Starting and Ending Dates of Service: Providers may bill for the start and end dates of an authorization.
3. Authorized Hours of Service to the Last Covered Day (LCD): The provider will be authorized to provide a total number of hours of service from the date of the authorization, until the Last Covered Day (LCD) of service. The provider is responsible to manage the use of those hours over the authorized period of treatment, and the allocation of those hours between the clinician and the BHP, consistent with the ITP. Please see B.5 Other Standards of Care for information on utilization management.
4. Presence of Member and Parent/Caregiver: Except for collateral time (as noted below), the member and/or parent/caregiver must be present for this service to be billed. It is expected that all billed services for 65M are closely linked to the family treatment goals, even when the parent/caregiver is not present.

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5. Collateral Billing: MaineCare reimburses only up to ten (10) hours of collateral contacts per member per year of service. Each provider that serves a member may bill up to ten (10) hours of collateral contacts per year of service that they provide. There is no need to track collateral billing across providers who serve the same member at different times.
6. Phone Calls: Phone calls are not billable.
7. Concurrent Services: Services that may be billed concurrently with Section 65 M or 65 N:
 - a. Section 24, Day Habilitation Services for Persons with Mental Retardation
 - b. Section 65 A, Emergency Services
 - c. Section 65 C, Crisis Resolution Services
 - d. Section 41, Educational Day Treatment
 - e. Section 13.12, Targeted Case Management
 - f. Section 65 E, Infant Mental Health
 - g. Section 65 F, Outpatient Services are allowable concurrent with 65M/N in the following circumstances:
 - i. There is a clear clinical justification as to why outpatient therapy is needed in addition to 65M/N. For example, such justification could be that the member is already involved with a therapist for specialized therapy (e.g. trauma, sexual abuse issues, and substance abuse) or that the member's relationship with the therapist is critical to the success of the family treatment provided in 65M/N.
 - ii. During the course of provision of Section 65 M/N services the clinical team uncovers an issue requiring referral to specialized therapy (e.g. trauma, sexual abuse issue, substance abuse).
 - iii. The member can enter outpatient therapy 3 weeks prior to discharge from 65 M/N services.
 - h. Section 65K, Medication Management
8. Non Concurrent Services: Services that may not be provided at the same time as 65 M/N:
 - a. Section 65 B: Day Treatment (non-educational)
 - b. Section 65 D, Crisis Support Services
 - c. Section 65 G, Children's Family and Community Support
 - d. Section 65 H, Children's Behavioral Health Services
 - e. Section 65 I, Family Psycho Education
 - f. Section 65 J, Assertive Community Treatment (ACT)
 - g. Section 37, Home Based Mental Health
 - h. Section 46 Psychiatric Facility Services
 - i. Section 97 Private Non-Medical Institution Services
 - i. Members in Psychiatric Hospitals or Crisis Units:
When a member is admitted to Section 46 Psychiatric Facility Services or a Crisis Unit, 65N providers may only bill for collateral contact (as described in item 5 above). 65M providers may bill for work with the parents/caregivers as usual, if it is expected that the member will be discharged back to the community within 30 days or less.

It is expected that if a member is admitted to a psychiatric hospital or a crisis unit, the provider will contact their regional BCA to ensure that the service provided in these situations is consistent with 65M/N treatment criteria. The provider will

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discuss the member's change in status and their plan to provide service, and to facilitate a successful reunification of the member and family.

ii. 65M/N Service Prior to Discharge from a longer term Residential/Crisis or Hospital Placement:

30 Days prior to discharge from a residential program, crisis unit or psychiatric hospital, the 65M/N provider may begin service, to assist the successful transition of the member into the home/community.

9. When the Member is Unavailable: When a member is unavailable (homeless, runaway, etc.) 65N providers may only bill for collateral work as described in item 5 above. 65M providers may bill for work with the parents/caregivers as usual, if it is expected that the member will be reunified with the family within 30 days or less.
10. When previous authorization has not been cancelled and another authorization is requested in the same time period. BMS will suspend payment of a claim when there are two authorizations for the same time period.
11. Data Integrity
The providers are responsible for the accuracy of all demographic data on the submitted authorizations.
12. CBHS Record Keeping and File Saving:
CBHS will maintain records in accordance with DHHS Privacy/Confidentiality Policy # 03-AP-17, issued 8/20/03.

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Appendix

1. System of Care Principles
2. Wraparound Process
3. Clinical Models: Key Elements for Practice
4. Clinical Criteria for CFBHTS Section 65M
5. Clinical Criteria for CBTCWPS Section 65N
6. Transition Process for those Receiving or on Wait Lists for 65 H/G Services
7. CE/UR Process Summary
8. CE/UR Packets: Content Details
9. CGAS
10. Required Forms List

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Appendix #1

System of Care Principles

- Clear and prompt access to an array of services
- Timely determinations of eligibility
- Individualized plans of care developed by the member & family planning team, with maximization of consumer/family choice and use of natural support systems
- Strength-based approach to each member's assessment and development of the individual's treatment plan
- Services are delivered in the least restrictive & least intensive setting, (home & local community) appropriate in type, and frequency to each member's developmental level
- Demonstrated family involvement and participation in all phases of service delivery
- Treatment services provided are evidence based or promising approaches
- Collaboration and Integration are required
- Demonstrated cultural competency in the delivery of services

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Appendix #2

Wraparound Process

Wraparound is a family centered, community oriented, strengths-based, highly individualized planning process aimed at helping people meet their unmet needs both within and outside of formal human services systems, while they remain in their neighborhoods and homes, whenever possible. The Wraparound Process is based on a set of values, beliefs, and principles that ensure that it is:

- Compassionate
- Individualized
- Family Centered
- Strengths Based
- Culturally Competent
- Team Developed and Supported
- Outcome Focused
- Needs Driven
- Flexible
- Flexibly Funded
- Unconditional
- Normalized
- Community Based

These values have implications for:

- Direct Practice
- Program Design and Implementation
- Systems of Care

Wraparound Plans include three types of supports and resources:

- Categorical services, designed for a "category" of people and funded with a certain category of money, are used when they fit well and meet needs.
- Modified categorical services, the above, but tailored in some way to fit a family or individual better and thus, better meet needs.
- Unique supports and resources that have been developed to best fit a particular person or family and meet their needs.

E.M. Grealish, M.Ed., Community Partners Inc. (2000)

More information about Wraparound is available at www.wraparoundsolutions.com

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Appendix #3

**Clinical Models: Key Elements for Practice
Commonalities of Home Based Evidence-Based Models**

- All models are time limited (on average 3-5 months)
- Take place in the member's home and community.
- Parental involvement is major component of the models to teach skill and understand development, behaviors, and interactional patterns.
- Interventions are goal specific.
- Increase responsibility for members and families in the treatment process.
- Empower parents with the skills and resources needed.
- Collaboration between the member, family, and team in development of treatment plan.
- Focus is on behavior change of the member and family, not insight oriented therapies.
- Clinician has the responsibility to engage with the member and family and identify barriers and develop strategies with the member and family if there is a lack of engagement.
- Models are Strength Based and focus interventions on member and family's strengths.
- Models take a multisystemic approach.
- Two person team (1 Clinician and 1 Bachelor Level Staff) to provide the treatment.
- Clinical supervision to ensure adherence to the specific model.

Functional Family Therapy:

Article: Functional Family Therapy
Office of Juvenile Justice and Delinquency Prevention
Juvenile Justice Bulletin, December 2000
Thomas L. Sexton and James F. Alexander

Core Principles and Goals: Functional Family Therapy is based on the belief that the primary focus of intervention is the family, and to reflect an understanding that positive and negative behaviors both influence and are influenced by multiple relational systems (i.e., are functional).

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FFT is a Multisystemic prevention program, meaning that it focuses on the multiple domains and systems within which children and their families live. FFT works first to develop family members' inner strengths and their abilities to improve their situations. These characteristics provide the family with a platform for change and future functioning that extends beyond the direct support of the therapist and other social systems. In the long run, the FFT philosophy leads to greater self-sufficiency, fewer total treatment needs, and considerably lower costs. "Strength based" is core to this approach.

Techniques: Cornerstone of FFT's clinical practice is the use of the Intervention Map. The map forms the basis for responsive clinical decisions. The map identifies treatment strategies with a high probability of success and assists the therapist's understanding of the family and child. FFT practice is systemic and individualized. Treatment involves three phases. Phase I is engagement and motivation. Phase II is on behavior change. Phase III is on generalization. FFT combines and integrates the following elements into a clear and comprehensive clinical model: established clinical theory, empirically supported principles, and extensive clinical experience.

Staffing: Trained professional with a Master's degree.

Time Frame: Average of 8-12 sessions (time limited) for mild cases and up to 30 hours of direct service for more difficult cases. These sessions are spread over a three-month period.

Evidence: Data from numerous studies indicated that FFT reduced recidivism 25-60% more effectively than other programs. It was a cost effective way of bringing about change.

Intensive Home Based Program for Members and Members (IHB): Providence Model:

Article: Intensive Home based Program (IHB) Outcome Evaluation; February 2004

Executive Summary, Sally Stevens PhD, Bridget Murphy, & Christine Bracamonte-Wiggs, MHP, University of Arizona.

Core Principles and Goals: The goal of the IHB program is to keep the child in the home and the community as well as to move the child and the family to a place of stability and less intensive services. The treatment addresses issues within the family's own environment, treats the entire family, has a collaborative approach and enhances the existing family strengths.

Techniques: The cornerstone of Providence's IHB program includes 1) Intensity, 2) Setting (Natural environments) and 3) Frequency and Quality of case staffings. Case staffings are conducted weekly with the respective treatment team presenting the case to other IHB teams. Treatment progress as well as lack of progress is discussed along with the facilitator's perceived barriers to positive change. The child is viewed as the "case" set within the context of the family, environment, culture and inherent characteristics (i.e. developmentally delayed; physically disabled). The program is divided into phases. These include entry (1-3 weeks), stabilization (4-8 weeks) and step down (4-8 weeks). Treatment also provides pre and post measurement behavioral functioning, for a total of 12 weeks (time limited).

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Staffing: A team approach is used with a Master's level clinician and a bachelor's level counselor. Crisis services are rotated among team members to provide 24/7 crisis coverage.

Time Frame: The average length of the program is 90 to 120 days. During the first 3 months the services are intensive and include 3-5 sessions each week which range from 1-4 hours in length. During the 4th month the child is transitioned from the IHB program to other community and school based services as needed.

Evidence: Outcome data supports the success of the IHB program for assisting children and their caregivers in making positive changes. One-quarter were assessed to have resolved all of their presenting issues and approximately half evidenced partial resolution.

Multisystemic Treatment (MST):

Henggeler, S.W., Schoenwald, S.K., Rowland, M.D., & Cunningham, P.B. (1998). Multisystemic treatment of antisocial behavior in Children and Adolescents. New York: Guilford Press.

Core Principles and goals: The primary goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and empower children to cope with family, peer, school and neighborhood problems. MST uses 9 treatment principles to formulate the assessments and treatment goals. It is through these nine principles that therapeutic integrity is maintained.

Techniques: The MST model uses the analytical (not "Psychoanalysis") process to help clinicians generate hypothesis about what combinations of factors sustain a problem behavior. Evidence is gathered to support the hypothesis. The interventions are used to test and challenge the hypothesis. Information is gathered from and around all of the systems that the child is involved in i.e. home, school, peers, and community. The treatment is delivered in the natural environment of the home, school and community. The treatment is family driven.

Staffing: MST therapists are full time master's level or highly competent bachelor's level, professionals assigned to the MST program solely. Teams include 2-4 clinicians plus a supervisor. Caseloads do not exceed 6 families. There is 24/7 crisis coverage on call system.

Time Frame: Duration of treatment is 3-5 months. Frequency of treatment sessions varies in accordance with the changing circumstances, needs and treatment progress.

Evidence: Multiple studies have been conducted around the efficacy of the MST model. An average of 33% of all children demonstrate improvement 18 months post discharge.

Intensive, In-Home, Child and Adolescent Psychiatric Service (IICAPS):

Article: Adapted from Joseph Woolston, M.D.
Yale Member Study Center

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Core Principals and goals: To develop new and stable child/micro-system interactions so the risk of out of home institutional interventions is significantly reduced. It is time limited problem focused, and does not seek to resolve all of the difficulties facing the child and family. It adheres to four major principles; Transparency, Practicality, Immediacy, and Adherence to the Specified Model (Principles, Concepts, Tools, and Techniques). Discharge goals include the child and family having stable connections with professional and natural supports including outpatient pharmacotherapy, psychotherapy, individualized school plan and supportive after school activities.

Techniques: IICAPS team joins with the family by providing direct in-home psychiatric treatment, intensive case management services, and 24/7 mobile crisis interventions. Treatment includes 3 phases with the first being Assessment and Engagement. The assessment phase includes the assessment of four specifically identified domains. The second phase is Work and Action and the third phase is Ending and Wrap-up.

Staffing: IICAPS uses a two provider team supervised weekly by a senior licensed mental health professional. The two provider team consists of a license eligible or licensed mental health provider and a bachelor's level mental health professional.

Time Frame: Time limited 3-6 months.

Evidence: Early studies show significant promise for this model.

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Appendix #4

Clinical Criteria

Child and Family Behavioral Health Treatment (Section 65M)

Child and Family Behavioral Health Treatment Service (CFBHTS) is a time limited, multidisciplinary, multimodal treatment program that is provided in a home or community settings, (typically 2-3 hours per day, 2 to 3 times per week, for 1-6 consecutive months). Frequency and intensity will be individualized.

This level of care is used to intervene in complex clinical situations through treating the child in his/her family system and employs behavioral interventions directed towards achieving improved child and family functioning.

This program is for members with serious emotional disorders and their families. This is for members for whom other less intensive levels of service (e.g. traditional outpatient services) have not been effective or are extremely unlikely to be effective.

Treatment authorizations will not exceed 90 days. Reauthorization for services beyond 6 months may be granted at the discretion of the Medical Director or designee, based on medical necessity, clinical information submitted by the Child & Family team and scores on standardized assessment scales. As functioning improves, the member and family will receive a diminishing number of treatment hours. All Treatment Plans must be individualized and should focus on addressing the presenting problem requiring this level of treatment. The member will transition to community outpatient treatment and/or natural support systems as soon as they can be appropriately treated at a lower level of care.

First response crisis assessment and consultation to the member and family should be available from the CFBHTS during normal working hours. If the CFBHTS team is unable to respond to or resolve the crisis, a referral may be made to the statewide crisis services.

Parents/caregiver/guardians will be actively involved in a significant portion of treatment sessions, as documented in the individual treatment plan. This has been found to be important to the success of treatment for children and adolescents. Active participation will mean sharing in the identification of child and family strengths, natural supports, and the definition of the primary problem. The family will be involved in planning appropriate responses, following through with the responses, assessing outcomes of the new parenting and child behavior, and beginning the cycle again with planning new refined responses.

Service may be discontinued if the parent/caregiver/guardian fails to actively participate in the treatment as prescribed in the treatment plan and it is shown that the provider has made adequate attempts to engage the parent/caregiver in the treatment process.

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Admission or Eligibility Criteria

See the MaineCare Benefits Manual, CH II, Section 65M

Exclusion Criteria

Any of the following criteria are sufficient for exclusion from this level of care:

1. The member is a danger to self and others or sufficient impairment exists that a more intensive level of treatment is required.
2. The member requires a level of structure and supervision beyond the scope of the program.
3. The member can be safely maintained and effectively treated at a less intensive level of care.
4. The parent/caregiver/guardian (Section 65M Only) or the member alone (Section 65N Only) is unwilling to be actively involved in the treatment provided in this program, and there is clear demonstration that the provider has made adequate attempts to engage the parent/caregiver or member alone in the treatment process.

Individual Treatment Plan (ITP) Requirements

Consistent with licensing requirements, all of the following must be included in the treatment plan:

1. Description of the primary reason for this service
 - a. Description of the nature of the impairment and the baseline measurement of identified problem(s)
 - b. The goals and objectives in the proposed ITP must be SMART:
 - i. Specific
 - ii. Measurable
 - iii. Attainable
 - iv. Realistic
 - v. Time Limited
2. 5 Axis most recent version of the DSM or D-C 0-3 diagnosis.
3. Current CAFAS Assessment (within 30 days).
4. Description of identified strengths/resources for the:
 - a. Member
 - b. Family/Caregivers
 - c. Community
5. Description of Evidence Based/Best Practice Treatment method to specifically address the reason for the service
6. Description of means of measuring the progress towards the identified objectives, including baseline measurement
7. Estimated last date of service.
8. Discharge Plan/Criteria

Treatment Re-Authorization Criteria

All of the following criteria are necessary for the treatment to be re-authorized at this level of care:

1. The member's condition continues to meet admission criteria for this level of care.
2. The need for continuation beyond 90 days of service as indicated by:
 - a. Continued clinical need, as demonstrated by clinical information and assessment tools

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- b. Evidence that the current treatment approach has been effective during the past 3 months and is likely to continue to be effective during the next one-three months.
3. The member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
4. Treatment planning is individualized.
 - a. Goals and objectives have been modified to address any change in needs due to progress.
 - b. Goals and objectives have been modified to address any lack of progress.
5. Progress related to the identified reason for referral is clearly evident and can be described in measurable terms or progress is expected with new or modified treatment goals.
6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
7. Treatment is rendered in a clinically appropriate manner and focused on the member's behavioral and functional outcomes as described in the Admission/Discharge information.
8. Section 65M Only: There is documentation to indicate that parent/caregiver/guardian participation meets the goals stated in the treatment plan.
9. There is documented active discharge planning for ending the service within the next 3 months.

Discharge Criteria

Any of the following criteria are sufficient for discharge from this level of care:

1. The member no longer meets admission criteria, i.e. now meets criteria for less or more intensive level of care.
2. The member and/or parent/caregiver/guardian withdraw consent for treatment.
3. Support systems which allow the member to be maintained in a less restrictive treatment have been developed.
4. The member is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care.
 - a. Member requires a higher level of care as evidenced by lack of sustained progress.
 - b. Service has continued for the maximum allowable 12 months without any appreciable change in member's symptoms/behaviors.

Level of Service Intensity Examples

The following levels of service intensity are presented as instructional examples to providers. CBHS believes treatment for members and families who meet the medical necessity criteria for 65 M will require treatment plans that are individualized to the particular needs of each member and their family. As described below, members requiring the most intense treatment will benefit from higher levels of licensed clinician involvement than members and families who are more stable. CBHS strongly suggests that each provider organization tailor the involvement of the treatment team members to address the specific treatment needs of each family.

High Level of Intensity:

1. This level of service is utilized by members requiring the highest level of intensity and will require the greatest amount of family involvement with the clinical team.
2. Members who at this level will usually have a CGAS score in the 30-40 range, and a CAFAS or PECFAS score of 100-130, and signs of significant family challenges.

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3. Other factors may be used in determination of the level of service (e.g. family issues and strengths, or cognitive limitations in the member or family).
4. Treatment hours shall be based on the individual member's needs and typically consist of 4-10 hours weekly.
5. The licensed clinician will usually have direct involvement with the member/family at least 50-75% of the hours served, with the remaining hours provided by non-clinical staff. Reasons for lower levels of clinician involvement must be clearly documented in the treatment plan.

Low Level of Intensity:

1. This level of service shall be utilized as a part of the transition to lower levels of care or natural community supports, as the member prepares to exit Section 65M services. This level of intensity may be an entry level based on the clinical condition of the identified member as reflected in the CGAS and CAFAS scores.
2. Members, who qualify for this level of services, will usually have a CGAS score of 40-50 range, and a CAFAS or PECFAS score of 70-90.
3. Other factors may be used in determination of the level of service (e.g. family issues and strengths, or cognitive ability in the member or family).
4. Treatment hours shall be based on the individual member's needs and typically consist of 2-5 hours weekly.
5. The Clinician will usually have direct involvement with the member/family at least 25-50% of the hours served, with the remaining hours provided by non-clinical staff. Reasons for lower levels of clinician involvement must be clearly documented in the treatment plan and authorized by CBHS or their designees.

The level of intensity determination will be made by service provider based upon the clinical assessment of the member and family. The service provider will clearly document this determination in the treatment plan and will outline the services to be provided including the involvement of the licensed clinician and that of the non-clinical staff, as noted earlier in this manual.

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Appendix #5

Clinical Criteria

Community Based Treatment for Children Without Permanency (Section 65N)

Community Based Treatment for Children Without Permanency (CBTCWP) is a time limited, multidisciplinary, multimodal structured treatment program that is provided in community settings, typically 2-3 hours per day, 2 to 3 times per week, for 1-6 consecutive months. Frequency and intensity will be individualized.

This level of care is used to intervene in complex clinical situations and employs behavioral interventions directed towards achieving improved functioning of the member in the community.

This program is for members with serious emotional disorders (SED), who have no parent or caregiver participating in their treatment, and who do not live or plan to live with a parent or caregiver. Other less intensive levels of service have not been effective or are extremely unlikely to be effective.

Treatment authorizations will not exceed 90 days. Reauthorizations beyond 6 months may be granted at the discretion of the Medical Director or designee, based on medical necessity, clinical information submitted by the member and other significant individuals in the member's life, as well as scores on standardized assessment scales. As the member's functioning improves, the member will receive a diminishing number of treatment hours. All treatment plans must be individualized and should focus on addressing the presenting problem requiring this level of treatment. The member will transition to community outpatient treatment and/or natural support systems as soon as they can be appropriately treated by a lower level of care.

First response crisis assessment and consultation to the member should be available during normal working hours. If the CBTCWP Services team is unable to respond or resolve the crisis, a referral may be made to statewide crisis services.

Service will be discontinued if the member fails to actively participate in the treatment as prescribed in the treatment plan and it is shown that the provider has made adequate attempts to engage the member in the treatment process.

Admission or Eligibility Criteria

See the MaineCare Benefits Manual, CH II, Section 65N

For all the following, please see the previous Appendix #4, Clinical Criteria for Section 65M:

Exclusion Criteria

Individualized Treatment Plan (ITP) Requirements

Treatment Re-Authorization Criteria

Discharge Criteria

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Level of Service Intensity Examples

The following levels of intensity are presented as instructional examples to providers. CBHS believes treatment for members who meet the medical necessity criteria for 65 N will require treatment plans that are individualized to the particular needs of each member. As described below, members requiring the most intensive treatment will benefit from higher levels of licensed clinician involvement than members who are more stable. CBHS strongly suggests that each provider organization tailor the involvement of the treatment team to address the specific treatment needs of each member.

High Level of Intensity:

1. This level of service is utilized by those members requiring the highest level of intensity and will require the greatest amount individual and support network involvement with the clinical team.
2. For this level of intensity, the member will usually have a CGAS score in the 30-40 range, and a CAFAS score of 100-130, and signs of significant community dysfunction.
3. Other factors may be used in determination of the level of service (e.g. severe psychosocial stressors, or cognitive limitations of the member or caregivers).
4. Treatment hours shall be based on the individual member's needs and typically consist of 4-10 hours weekly.
6. The licensed clinician will usually have direct involvement with the member at least 50-75% of the hours served, with the remaining hours provided by non-clinical staff. Reasons for lower levels of clinician involvement must be clearly documented in the treatment plan and authorized by CBHS or their designees.

Low Level of Intensity:

1. This level of service is utilized as a part of the transition to standard outpatient services or natural community supports, as the member prepares to exit Section 65N services. This level of intensity may be an entry level based on the clinical condition of the identified member as reflected in the CGAS and CAFAS scores.
2. For this level of services, the member will usually have a CGAS score in the 40-50 range, and a CAFAS score of 70-90.
3. Other factors may be used in determination of the level of service (e.g. severe psychosocial stressors, or cognitive limitations in the member or caregivers).
4. Treatment hours shall be based on the individual member's needs and typically consist of 2-5 hours weekly.
7. The Clinician will usually have direct involvement with the member at least 30-50% of the hours served, with the remaining hours provided by non-clinical staff. Reasons for lower levels of clinician involvement must be clearly documented in the treatment plan and authorized by CBHS or their designees.

The level of intensity determination will be made by the service provider based upon the clinical assessment of the member. The service provider will clearly document this determination in the treatment plan and will outline the services to be provided including the involvement of the licensed clinician and that of the non-clinical staff.

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Appendix #6

Transition Process into Section 65M or 65N Services for Members Receiving or on Wait Lists for 65 H or 65G Services

A. Members who currently receive 65H or 65G services and choose to continue with the same provider agency for 65M/N services:

1. Need for 65M/N Service is determined by member/family/team at the time of the 90 day review.
2. 65M/N Transition Form is completed by either the Case Manager or the 65H or 65 G Provider (as the team decides) at the time of client's 90 day review, or no later than two weeks prior to the end of the 90 day **transition period** for 65M/N.
 - a. The Transition Form is submitted to the Regional CBHS office.
3. **65H Providers only:** Within 5 business days of 65H services being terminated the provider (or the case manager, as the team decides) submits a Change of Status form reporting the termination of services, to the Regional CBHS office (no later than the 90th day after the 65 M/N rules go into effect).
4. After the 90th day of the **transition period**, of 65 M/N Services, the Transition Form and process are no longer in effect. For members in that situation, a new referral must be made for Section M/N services.
5. The current provider of 65H or 65G may continue to provide 65H or 65G service for up to 90 days after the 65M/N rules go into effect, or the member transitions to 65 M/N services, whichever comes first.
6. Specific exceptions to #5 above may be granted by the CBHS Medical Director. Please refer to the transition subsections in the 65G and 65H portions of the Section 65 rule and Section C below.
7. A transition plan will be developed by the 65 M/N clinician with the member, family (for 65M) and team, including the 65H or 65G provider.
8. This team will determine the hours of treatment in 65 M, recognizing that this is a very different treatment service from 65H or 65 G. The member and family will be authorized for up to 90 days of treatment, or until their quarterly review, whichever comes first.

Required Documentation:

DHHS Transition Form for MaineCare Section 65 M/N

Change of Status Form (CSF) - **65H Providers Only**

B. Children who currently receive 65H and 65 G Services and have a continued need for treatment services and request or require a new provider of Section 65M/N service or the current G or H provider chooses not to provide 65M/N Services:

1. Children and families in this situation are regarded as new referrals for 65M/N services.
2. The need for the 65M/N Service is determined by the member/family/team at the time of the 90 day review.
3. The current provider may continue provision of 65H or 65G service during and to the end of the 90 days of the **transition period** of 65M/N service.

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4. At the time of determination, The Case Manager or the 65H or 65G provider (as the team decides) completes the Central Enrollment Referral Packet, and submits to the Regional CBHS office.
5. At the end of the 90 days, if the new referral has not been assigned to a provider for assessment and service for 65M/N, it will be reported on the waiting list, and assigned to a provider as soon as capacity is available.
9. **65H Providers only:** Within 5 business days of 65H services being terminated the provider (or the case manager, as the team decides) submits a Change of Status form reporting the termination of services, to the Regional CBHS office (no later than the 90th day after the 65 M/N rules go into effect).

Required Documentation:

Central Enrollment (CE) Referral Packet

- Children's Enrollment Form (CEF)
- DHHS Referral Form for 65M/N
- Psychosocial Assessment with Diagnosis - most recent

Change of Status Form- **65H Providers Only.**

C. Requesting an Extension, to Provide 65GorH Services Beyond the 90 Day Transition Period:

1. An extension to provide Section G or Section H services beyond the 90 day transition period may be requested only under the following circumstances:
 - a. The child would be eligible for services under Section 65A.02 (M) or 65A.02 (N); and
 - b. Services under Section 65A.02 (M) or 65A.02 (N) are not available to the particular child within 90 days of the effective date of these rules, for reasons outside the control of the child or parent, for example, the unavailability of a provider in the area.
2. Members and families in this situation are regarded as new referrals for 65M/N services.
3. The need for the 65M/N Service is determined by the member/family/team at the time of the 90 day review.
4. The current provider may continue provision of 65H or 65G service during and to the end of the 90 days of the **transition period** of 65M/N service.
5. The Case Manager or the 65H or 65G provider (as the team decides) completes the Central Enrollment Referral Packet, and submits to the Regional CBHS office.
6. At the end of the 90 days, if the new referral has not been assigned to a provider for assessment and service for 65M/N, it will be reported on the waiting list, and assigned to a provider as soon as capacity is available.
7. A written request for an extension of Section G or H services beyond the 90 day transition period may be submitted to the DHHS- Children's Behavioral Health Services Medical Director if the following are satisfied:
 - a. The criteria in C(1)(a) above are met;
 - b. The child has already been referred to 65M/N services, and is on the wait list;
 - c. The member/family/team feel that the member has a need for Section G or H services beyond the 90 day transition period; and

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- d. The provider chooses to provide Section G or H services after the end of the 90 day transition period.
8. The written extension request must include the following:
 - a. A letter describing:
 - i. Why this service extension is needed;
 - ii. The progress that the member has made in the existing service;
 - iii. The anticipated progress that is expected in continuing the service.
 - b. A copy of the most recent Treatment Plan that includes:
 - i. An estimated discharge date from the 65 G or H service;
 - ii. A goal with action steps regarding the appropriate transition of the member and family to a 65M service as soon as it is available.
9. The Department will send a written denial or approval to the member/family and provider within 5 days of receiving the request.
10. An authorization for extension of the 65 G or H service will be for a time period of up to 90 days or until the member receives 65M/N services, **whichever comes first**.
11. While receiving Section G or H services that have been extended beyond the 90 day transition period, a member will at the same time be on the wait list for 65M/N services, and will be expected to appropriately discharge from the G or H service and transition to the 65M/N service when the 65M/N program is able to begin service.
12. If the service extension authorization expires before the member begins service with a 65M/N provider, then the Section G or H provider may request another extension of service, following steps 7-11 noted above. The new service extension request must be submitted **at least 5** working days before the last covered day of service.
13. If the member/family chooses to close with the Section G or H service, and also chooses not to receive 65M/N services, then within 5 days of discharge from the G or H service, the provider must submit a Change of Status Form to the Department.

Required Documentation:

- A letter from the provider, as noted above
- An updated Treatment Plan, as noted above
- If discharged, and no longer choosing 65M/N: Change of Status Form (CSF)

D. Members currently receiving 65 H or 65G Services Who Will Not be Referred for 65 M/N Services:

1. At the member's 90 day review the member/family and team decide that a referral to 65M/N services is not appropriate.
2. The provider, member/family and team will plan for the clinically appropriate termination of the service, with an appropriate discharge plan.
3. **65H Providers only:** Within 5 business days of 65H services being terminated the provider submits a Change of Status form reporting the termination of services, to the Regional CBHS office (no later than the 90th day after the 65 M/N rules go into effect).

Required Documentation: Change of Status Form (CSF) - **65H Provider Only**.

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E. Members Currently on the Wait List for 65H or 65G Services

1. If a need for the 65M/N Service is determined by the member/family/team, and they choose to receive 65M/N services, then they are considered eligible for the service and will automatically be placed on the wait list without loss of accumulated days waiting;
2. **65H Services Only:** The member's Case Manager or the family must notify CBHS Central Enrollment staff that they wish to be assigned to a 65M/N provider.
3. **65G Services Only:** The total number of "days waiting" for service begins with the original referral date of the member to the Section G service for which they have been waiting. The member's Case Manager or the family (with DHHS assistance) must submit a 65M&N Transition Form to the Regional Office.
4. The member/family is considered eligible to be assigned to a provider, and to receive the 65M/N initial assessment, and treatment planning as soon as a provider has capacity.

Required Documentation: 65M&N Transition Form- **65G Services Only**

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**Appendix#7
CE/UR Process Summary for Sections 65M&N Services**

| CE/UR Process: | Time frame | Packet to Submit: | Person Responsible | Outcome: |
|--|--|---|---|--|
| Provider Notifies Regional CBHS staff of Available Capacity for new members | Weekly; schedule and method used, as arranged with the Regional CBHS staff | | 65M/N Agency staff | CBHS Central Enrollment staff have weekly capacity info |
| <u>Central Enrollment Referral</u> | *Submit referral within 5 days of determining need *CBHS determine Eligibility. BCA determine LOC in 2 days | <u>Central Enrollment (CE) Referral Packet; Fax to Regional CBHS staff:</u> <ul style="list-style-type: none"> • CEF • DHHS Referral Form for 65M/N • Assessment with Dx | Referral Source (Case Manager, Provider staff, family member etc) | Referral made for 65M/N service |
| Member/ Provider Match | As needed | | CBHS Regional staff | Member referred to provider and Assessment Authorized |
| Perform Authorized Assessment | 30 Days | | 65M/N Clinician | 8 hours of Psycho-social Assessment, including: Dx (DSM or DC 0-3); Stand. Tool; Develop ITP |
| <u>Treatment Authorization</u> | <u>Due:</u> No more than 30 days after Assessment first authorized <u>BCA:</u> 5 days to reply to provider | <u>Treatment Authorization Packet ; Fax to Regional BCA:</u> <ul style="list-style-type: none"> • Assessment • CAFAS/CGAS • Tx Authorization Form | 65M/N Clinician | Treatment, for up to 90 days, for a specified total # of hours, estimated avg hours per week and est. hours for clinician/BHP. |
| <u>Treatment Re-Authorization</u> | <u>Due:</u> 5 days prior to the Last Covered Date (LCD) of service <u>BCA:</u> 5 days to reply to provider | <u>Treatment Re-Authorization Packet ; Fax to Regional BCA:</u> <ul style="list-style-type: none"> • Tx Re-Authorization Request Form • CAFAS/CGAS | 65M/N Clinician | Treatment for up to 90 days, for a specified # of hours per week. |
| <u>Discharge</u> | <u>Due:</u> No more than 5 days after member discharge from the service | <u>Discharge Packet; Fax to Regional BCA</u> <ul style="list-style-type: none"> • Discharge Summary • CEF Change Form • CAFAS/CGAS | 65M/N Clinician | Discharge of member from the service |
| To Request Re-Authorization beyond 6 months | <u>Due:</u> 5 days before the LCD of service <u>DHHS:</u> 5 days to reply to provider | <u>Extension Request Packet; Fax to Regional BCA:</u> <ul style="list-style-type: none"> • DHHS Re-Auth Request • Letter/CAFAS/CGAS | 65M/N Clinician | Determination regarding Extension Request |

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Appendix #8

CE/UR Packets: Content Details

1. Central Enrollment (CE) Referral Packet
 - Children's Enrollment Form (CEF)
 - DHHS Referral Form for 65M/N
 - Psychosocial Assessment with Diagnosis- most recent

2. Treatment Authorization Packet:
 - Psychosocial Assessment with Diagnosis
 - CAFAS Summary Scoring Sheet (done at time of this packet submission) or
 - PECFAS for members ages 3-5
 - Treatment Authorization Request Form

3. Treatment Re-Authorization Packet:
 - Treatment Re-Authorization Request Form
 - CAFAS Summary Scoring Sheet (done at time of this packet submission) or
 - PECFAS for members ages 3-5

4. Discharge Packet
 - DHHS Discharge Summary with CGAS score
 - Change of Status Form (CSF)
 - CAFAS Summary Scoring Sheet (done within 30 days of the Discharge) or
 - PECFAS for members ages 3-5

5. Extension Request Packet:
 - DHHS Re-Authorization Request Form
 - CAFAS Summary Scoring Sheet (done at time of this packet submission) or
 - PECFAS for members ages 3-5
 - Letter explaining why the provider believes further therapy will result in needed positive outcomes for the member and family.

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Appendix #9

CHILDREN'S GLOBAL ASSESSMENT SCALE

Rate the subject's most impaired level of general functioning for the time period by selecting the lowest which describes his/her functioning. Rate actual functioning regardless of prognosis. The examples are only illustrative.

Specified time period: the last 3 months

- 100-91 Superior functioning in all areas** (at home, at school and with peers), involved in a range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.). Likeable, confident, "everyday" worries never get out of hand. Doing well in school. No symptoms.
- 90-81 Good functioning in all areas.** Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasional "blow-ups" with siblings, parents or peers).
- 80-71 No more than slight impairment in functioning at home, at schools, or with peers.** Some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sib) but these are brief and interference with functioning is transient. Such children are only minimally disturbing to others and are not considered deviant by those who know them.
- 70-61 Some difficulty in a single area, but generally functioning pretty well** e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work, mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior. Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.
- 60-51 Variable functioning with sporadic difficulties or symptoms** in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not who see the child in other settings.
- 50-41 Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area,** such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other anti-social behavior with some preservation of meaningful social relationships.
- 40-31 Major impairment in functioning in several areas and unable to function in one of these areas,** i.e., disturbed at home, at school, with peers, or in the society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).
- 30-21 Unable to function in almost all areas,** e.g., stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g., sometimes incoherent or inappropriate).
- 20-11 Needs considerable supervision** to prevent hurting others or self, e.g., frequently violent, repeated suicide attempts OR to maintain personal hygiene OR gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.
- 10-1 Needs constant supervision** (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment reality testing, communication, cognition, affect, or personal hygiene.

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Appendix #10

Required Forms List

The following forms are required as part of providing 65M and N services:

1. Transition Form for those receiving 65 H/G services
2. Central Enrollment Form (CEF)
3. Change of Status Form
4. DHHS Referral Form for 65M/N
5. DHHS Treatment Authorization Request Form
6. DHHS Treatment Re-Authorization Request Form
7. CAFAS Summary Scoring Sheet
8. PECFAS Summary Scoring Sheet
9. Discharge Form