

## Review of Medical Necessity for Behavioral Health Rehabilitation Services

The following questions were formulated from the Commonwealth of Pennsylvania HealthChoices Behavioral Health Program standards and requirements, Appendix T part B Medical Necessity Criteria for BHRS. They are intended to aid the evaluator and provider in formulating a plan for using BHR services, and evaluating whether services are being delivered consistent with Wraparound, Recovery and CASSP principles.

### RATIONALE FOR TREATMENT

**Discussion:** All treatment should be goal directed. It is essential for providers to have accurate case conceptualization and the ability to enact effective interventions leading toward recovery. Failure of treatment in a less restrictive or less intrusive setting is not a requirement for BHRS. However, when less intrusive services would likely be effective, the initiation of BHRS is counter to CASSP principles and not in the best interest of the child.

1. Is the diagnosis in question?
2. Does the evaluation clearly provide enough information about this child's symptoms and course of illness to justify each diagnosis?
3. Are the purposes and goals for the proposed services justified and clearly stated?
4. Are services being substituted for indicated medication treatment?
5. Do safety issues indicate a higher level of restrictiveness is needed?
6. Are services being requested to meet a non-behavioral health centered need? (Such as child care, transportation, respite)
7. Does this child require intervention at the site where the problematic behaviors occur? Or is there a possibility of generalizing treatment objectives delivered in clinic based settings?
8. Does the BHRS provider offer the level of expertise necessary to address the child's presenting symptoms? Or are specialized services (such as trauma focused care, sexually maladaptive behavior treatment, eating disorder treatment) indicated?

## MULTISYSTEM INVOLVEMENT

1. What is this child's multi-system involvement? (mental health, mental retardation, education, children and youth, juvenile justice, drug and alcohol, etc)

2. What other child serving systems are indicated by the child's presentation and diagnoses?

3. Does this child have mental retardation?

3a. If so, what is the child's baseline level of functioning?

3b. What mental health crisis is driving the need for services?

3c. Are services being delivered in absence of other mental retardation services?

4. Are services to be delivered within the school?

4a. What school supports are in place for the specific symptoms being addressed?

4b. What is the evidence of collaboration with school staff?

4c. What school staff members are engaged in skill transfer?

4d. Is BHRS staff only performing interventions permitted by DPW guidelines?

5. Is this child using alcohol or other drugs?

5a. If so, has the child been assessed for/started substance abuse treatment?

## FAMILY INVOLVEMENT

**Discussion:** When services are necessary, it is essential that partnership with the family and natural caregivers ensure their primary responsibility and relationship with the child. Mental health services are by their very nature unnatural and are not intended to substitute for other relationships. All services are provided with the purpose of improving and developing the capacity of the child and family to function independently as a unit.

1. What is the parent/guardian's willingness to engage in treatment?

2. Does the parent or guardian agree to be present and participating for all hours of service?
3. What skills development will assist in furthering family autonomy in the care of children with special needs?
4. Are these skills being taught, modeled and coached?
5. How are services currently assisting the family in the development of their informal support network?
6. Have you incorporated into the planning the appropriate tapering of the service?
6a. What are parental concerns about tapering services?
6b. How are these concerns being addressed?
<b>NATURAL SUPPORTS</b>
<b>Discussion:</b> Integration/reintegration into the natural environment is assumed to be a universal goal. BHRS should lay the groundwork for independent functioning within the family and community systems. Discovering and building upon strengths and natural supports is essential to BHRS treatment.
1. Has the evaluation and prescription planned the replacement of the service with informal and other non behavioral health therapeutic supports?
1a. What supports are in place?
1b. What supports are still needed?
2. Are the child's interest areas and strengths documented, with a plan to explore new interests and strengths for the child?

3. Has there been recruitment of family members, or other significant individuals, to participate as designated support persons?
4. Do you have a list of the available services, events and activities in the community?
5. What activities has the child been involved in over the past two months? Is there a plan to continue this involvement?
6. Does the treatment plan include community integrative activities, such as planned parental supervised activities?
6a. Or age appropriate, child independent participation in planned community activities [such as: Traditional events/celebrations; school sponsored clubs and gatherings; extra-curricular classes (i.e. dance, music, martial arts, etc); church/community center/playground activities, etc?
6b. Or opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities (such as: neighborhood "hoops", stick ball, parties and informal gatherings]
7. Do the progress notes detail the outcome of the home/community integrative activity?
8. Is there a data gathering form or instrument to measure the outcome of a child's participation in a home/community activity?
9. What is the plan to expand the child's home/community/cultural participation?
10. Are at least 25 % of all planned interventions carried out through natural (non-mental health services) supports?
<b>COORDINATION OF CARE</b>
1. Where is the written evidence of coordination on an <i>ongoing basis</i> with the appropriate agencies to provide the necessary natural community based supports?
2. Are all involved caregivers and agencies present at the ISPT meetings?

## INTENSITY OF BHRS PRESCRIPTION

**Discussion:** Of the four severity levels, *level 1 through level 4*, the last two are intended to divert the child or adolescent from out-of-home services, or serve as a step down following the child's discharge from any inpatient or out-of-home placement. Ideally, each severity level would have a range of hours for serving a child in each of three categories: clinic/hospital services; home/community services; and the service inherent in the personal support network. Traditional outpatient and partial hospitalization services are examples of other services which may be coordinated with home/community delivered services when medically necessary.

1. Is the decision for basic services at *level 1 or level 2* based upon the presence of following factors?

- Serious/persistent emotional and behavioral impairment of functioning due to a psychiatric disorder other than mental retardation
  - Or: Psycho-social stressors impairing functioning at normal developmental level
  - Or: Step-down from a higher level of care, such as Residential Treatment or CRR host home
- Need for observation (such as FBA) to clarify treatment planning
- Need for support during medication regulation
- Risk of harm to self or others, including suicidal or homicidal ideation, impulsivity, aggression, severe social withdrawal or mood lability, psychosis or severely impaired judgment

2. Is the decision for higher services at *level 3 or level 4* based upon the presence of these additional factors?

- Amplified severity of impaired functioning
- Risk of out of home or out of school placement
- Demonstrated destruction of property due to mental illness
- Actual or imminent injury to self or others; intensive suicidal or homicidal threat

## RECOMMENDING CONTINUED BHRS TREATMENT

**Discussion:** Services should be effective to be continued. When no progress is made over time, different services or interventions must be considered. Additionally, when effective, services should not be continued beyond the time they are needed. Progress and change should spur recommendations to titrate services and work toward independence.

1. Are BHRS services improving the child's level of functioning and ability for self maintenance?

1a. If not, what other services should be considered?

2. Does this child continue to require intervention at the site where the problematic behaviors occur? Or is there a possibility of generalizing treatment objectives delivered in clinic based settings?

3. What is the utilization of services from the previous plan of care?

**RECOMMENDING DISCHARGE FROM BHRS**

1. Has the child met treatment goals to the extent that treatment may be delivered in a less intrusive setting?

2. Or, have services ceased to be effective?

3. Or, are services interfering with the development of a service-independent lifestyle?