This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

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1 Optum is a brand used by United Behavioral Health and its affiliates.
Admission Criteria

- The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
  - Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.
  - The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation including co-occurring behavioral health or medical conditions, informed by the information collected by the provider following evaluation and treatment planning described in the Common Best Practices.

AND

- The member’s condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of the member’s condition require the intensity and scope of services provided in the proposed level of care.

AND

- Co-occurring behavioral health and medical conditions can be safely managed in the proposed level of care.

AND

- Services are medically necessary.

AND

- For all levels of care, services must be for the purpose of diagnostic study or reasonably be expected to improve the member’s condition. The treatment must, at a minimum, be designed to reduce or control the member’s psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the member’s level of functioning.
  - It is not necessary that a course of therapy have as its goal restoration of the member to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some members. For many other psychiatric members, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. “Improvement” in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment were withdrawn the member’s condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
  - In addition to the above, for outpatient services, some members may undergo a course of treatment that increases their level of functioning but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, coverage depends on whether the criteria discussed above are met; for example, that stability can be maintained without further treatment or with less intensive treatment.

Continuing Stay Criteria

- The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active”, service(s) must be as follows:
  - Supervised and evaluated by the admitting provider;
  - Provided under an individualized treatment plan consistent with Common Clinical Best Practices;
  - Reasonably expected to improve the member’s presenting problems.

AND

- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

- Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.

AND

- The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated and feasible.
Discharge Criteria

- The continued stay criteria are no longer met. Examples include:
  - The member’s condition no longer requires care.
  - The member’s condition has changed to the extent that the condition now meets admission criteria for another level of care.
  - Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
  - The member requires medical/surgical treatment.
  - After an initial assessment the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

**COMMON CLINICAL BEST PRACTICES**

**Introduction**

In assessing whether the criteria set forth in these guidelines is satisfied, staff should consider the clinical information collected from the provider following evaluation and treatment planning described in Common Clinical Best Practices. Staff should update the clinical information through continued consultation with the provider at appropriate intervals as the treatment progresses, including information about new or different symptoms or conditions that may emerge in the course of treatment.

**Evaluation & Treatment Planning**

- The initial evaluation:
  - Gathers information about the presenting issues from the member’s perspective, and includes the member’s understanding of the factors that lead to requesting services;
  - Focuses on the member’s specific needs;
  - Identifies the member’s goals and expectations;
  - Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

- The provider collects information from the member and other sources, and completes an initial evaluation of the following:
  - The member’s chief complaint;
  - The history of the presenting illness;
  - The factors leading to the request for service;
  - The member’s mental status;
  - The member’s current level of functioning;
  - Urgent needs, including those related to the risk of harm to self, others, and/or property;
  - The member’s use of alcohol, tobacco, or drugs;
  - Co-occurring behavioral health and physical conditions;
  - The member’s history of behavioral health services;
  - The member’s history of trauma;
  - The member’s medical history and current physical health status;
  - The member’s developmental history;
  - Pertinent current and historical life information;
  - The member’s strengths;
  - Barriers to care;
The member’s instructions for treatment, or appointment of a representative to make decisions about treatment;
• The member’s broader recovery, resiliency, and wellbeing goals.
• The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
• The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to develop a treatment plan. The treatment plan addresses the following:
  • The short- and long-term goals of treatment;
  • The type, amount, frequency, and duration of treatment;
  • The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed, and related to the factors leading to admission;
  • How the member’s family and other natural resources will participate in treatment when clinically indicated;
  • How treatment will be coordinated with other provider(s), as well as with agencies or programs with which the member is involved.
• As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
• The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
• Treatment focuses on the member’s condition including the factors precipitating admission to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
• The treatment plan and level of care are reassessed when the member’s condition improves, worsens, or does not respond to treatment.
  • When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
  • When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.
• In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

Discharge Planning
• The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
• The provider and, whenever possible, the member updates the initial discharge plan during the admission, ensuring that:
  • An appropriate discharge plan is in place prior to discharge;
  • The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
  • The member agrees with the discharge plan.
• For members continuing treatment:
  • The discharge plan includes the following:
    • The discharge date;
The post-discharge level of care, and the recommended forms and frequency of treatment;
- The name(s) of the provider(s) who will deliver treatment;
- The date of the first appointment, including the date of the first medication management visit;
- The name, dose, and frequency of each medication, with a prescription sufficient to last until the first medication management visit;
- An appointment for necessary lab tests;
- Resources to assist the member with overcoming barriers to care, such as lack of transportation or child care;
- Recommended self-help and community support services;
- Information about what the member should do in the event of a crisis prior to the first appointment.

For members not continuing treatment:
- The discharge plan includes the following:
  - The discharge date;
  - Recommended self-help and community support services;
  - Information about what the member should do in the event of a crisis or to resume services.
  - The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

**ASSERTIVE COMMUNITY TREATMENT (ACT)**

**ASSERTIVE COMMUNITY TREATMENT (ACT)** is a multi-disciplinary, self-contained clinical team approach providing comprehensive mental health and rehabilitative services. Team members provide long-term intensive care in natural community settings. The team provides all mental health services rather than referring individuals to different mental health providers, programs, and other agencies. Major activities may include: memberspecific treatment planning – team meets daily to plan services, assesses individuals community status and share information to coordinate services; individual supports – for activities of daily living, financial management, skills training, medication support; coordination with collaterals – sharing information with healthcare and other providers; individual clinical interventions – therapy, diagnosis and assessment.

**Admission Criteria**
- See Common Admission Criteria
  AND
- The member’s physician recommends ACT, and attests that inpatient care would be necessary without this service.

**Continuing Stay Criteria**
- See Common Continuing Stay Criteria
  AND
- The member is not receiving community based mental health services from any provider other than the ACT provider.
  AND
- The member is not receiving psychosocial rehabilitation, senior psychosocial rehabilitation, or day support simultaneously with ACT.
Discharge Criteria

- See Common Discharge Criteria

Clinical Best Practices

- See Common Continuing Stay Criteria
- See Common Clinical Best Practices
- The Individual Service Plan is developed within the first 14 calendar days.
- The Individual Service Plan is updated at least every 30 calendar days.
- At the time of discharge, the provider gives the parent/guardian:
  - A written copy of the final discharge plan; and
  - A written prescription for a 30-day supply of all medications for the member if the current supply does not exceed 30 days.

**COMMUNITY SUPPORT SERVICES (CSS)**

COMMUNITY SUPPORT SERVICES (CSS) provides an array of support services delivered by community based mobile professionals. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

CSS not only assists the individual in gaining access to needed services necessary for community integration and sustainability within the community, but may also provide direct services such as supportive counseling/reality orientation, skills training, enlisting social supports, financial management counseling, and monitoring physical and mental health status.

Admission Criteria

- See Common Admission Criteria

Continuing Stay Criteria

- See Common Continuing Stay Criteria

Discharge Criteria

- See Common Discharge Criteria
- The enrollee reaches twenty-two (22) years of age or "ages out".
- The enrollee or family utilizes their freedom of choice to end services.
- The enrollee moves out of state.
- The enrollee no longer meets the criteria or needs the intensity of services.
- The enrollee is admitted to an acute care facility or Psychiatric Residential Treatment Facility (PRTF).

Clinical Best Practices

- See Common Clinical Best Practices
- CSS includes the following as indicated:
Identification of strengths which will aid the enrollee in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.

- Individual therapeutic interventions with an enrollee that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.
- Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and program toward goals.
- Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
- Direct interventions in deescalating situations to prevent crisis.
- Assisting the enrollee and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.
- Relapse prevention and disease management strategies.
- Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.
- Facilitation of the Individual Service Plan which includes the active involvement of the enrollee and the people identified as important in the enrollee’s life.

- The Individual Service Plan is developed within the first 14 calendar days.
- The Individual Service Plan is updated at least every 30 calendar days.
- At the time of discharge, the provider gives the parent/guardian a written copy of the final discharge plan.

**DAY TREATMENT**

**DAY TREATMENT** is a behavioral intervention program provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with Serious Emotional Disturbance (SED) the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants in a particular program and may include social skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution. The most important element of Day Treatment is the consistency and qualifications of the staff providing the service. Day Treatment is the most intensive outpatient program available to children and adolescents. Members may participate in the program a maximum of 5 hours per day, five days per week with a minimum of 4 hours per week.

Day Treatment provides an alternative to residential treatment or acute psychiatric hospitalization and/or serves as a transition from these services.

**Admission Criteria**

- See Common Admission Criteria
  AND
  AND
- The member has a Serious Emotional Disturbance.

**Continuing Stay Criteria**

- See Common Continuing Stay Criteria

**Discharge Criteria**

- See Common Discharge Criteria
- The member reaches 22 years of age.

**Clinical Best Practices**

- See Common Clinical Best Practices
• see "Clinical Best Practices" in the Level of Care Guideline, Day Treatment: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html
  • Day Treatment includes involvement of the family or individuals acting in place of the parents as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

**INTENSIVE OUTPATIENT TREATMENT**

**INTENSIVE OUTPATIENT TREATMENT** is an all-inclusive, psychiatric clinical suite of multifaceted services acting as a wrap-around to families with children/youth with Serious Emotional Disturbances (SED) for family stabilization in the home and community. It is used to diffuse a current crisis, stabilize the living arrangement and offer the family and children/youth alternatives to being crisis.

**Admission Criteria**

• See Common Admission Criteria
  AND
• see "Admission Criteria" in the Level of Care Guideline, Intensive Outpatient Program: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html
    AND
• The member has a Serious Emotional Disturbance.
  AND
• The member has a full scale IQ of 60 or above or, if the score is less than 60, there is evidence that the IQ score is suppressed due to the member’s behavioral health condition.
  AND
• Intensive Outpatient Program is recommended by the member’s provider, or is otherwise indicated by the results of a biopsychosocial assessment.
  AND
• The member needs specialized services and supports from multiple agencies including case management, and an array of clinical interventions and family supports.

**Continuing Stay Criteria**

• See Common Continuing Stay Criteria

**Discharge Criteria**

• See Common Discharge Criteria
• The member reaches 22 years of age.

**Clinical Best Practices**

• See Common Clinical Best Practices
• Intensive Outpatient Program includes involvement of the family or individuals acting in place of the parents as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.
Mississippi Youth Programs Around the Clock (MYPAC) are defined as services that are all-inclusive home and community based services that assist members and their families in gaining access to needed mental health services as well as medical, social, educational and other services regardless of the funding source for those other services and includes service coordination that involves finding and organizing multiple treatment and support services. Services are provided to members up to the age of 21 with serious emotional disturbance (SED) that:

- Exceed the resources of a single agency or service provider;
- Experience multiple acute hospital stays;
- Have been recommended for residential care;
- Have had interruptions in delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown;
- Are at immediate risk of requiring treatment in a Psychiatric Residential Treatment Facility (PRTF); or
- Are receiving services in a PRTF and are ready to transition back to the community.

**Admission Criteria**

- The member:
  - Must be up to the age of 21;
  - Must be diagnosed by a psychiatrist or licensed psychologist in the past 60 days with a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria for SED specified within the Diagnostic and Statistical Manual (DSM);
  - The member can participate and process information as evidenced by and appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness; and
  - Is currently a member of a PRTF or acute care facility who continues to meet the Level of Care (LOC) for residential treatment but can be transitioned into the community with MYPAC services or meets the same LOC for admission to a PRTF but can be diverted to MYPAC as an alternative to residential treatment.

- A member must be admitted prior to their 21st birthday; however, if a member is already receiving MYPAC services prior to age 21, they may remain in MYPAC until treatment is completed or the member’s 22 birthday, whichever occurs first.

**Continued Service Criteria**

- The following documents must be submitted by the provider:
  - A copy of the most current Individualized Service Plan indicating the necessity of continuing the current level of care. Plan should be dated no more than 30 days from the date of the request.
  - A copy of the Child and Family Team Meeting Notes for the past 2 meetings, one of which must have been within the last 30 days.

**Discharge Criteria**

- Discharge from MYPAC services occurs when:
  - The member reaches 22 years of age;
  - The family utilizes their freedom of choice to end services;
  - The member moves out of state;
  - The member no longer meets the criteria or needs the intensity of services provided; or
  - The member is admitted to an acute care facility or PRTF.

- The wraparound facilitator must access and link appropriate services to the member and family prior to discharge.

- At the time of discharge from MYPAC, the provider must give the parent/guardian:
  - A written copy of the final discharge plan; and
  - A written prescription for 30 day supply of all medications used for the management of the member’s SED if the current supply does not exceed 30 days.
• The provider must obtain signed consent from the member and family to provide copies of the final discharge plan to the providers of follow-up mental health, education and other agreed-upon services to be provided after discharge.

**Clinical Best Practices**

• At the time of the member’s discharge from MYPAC services, the discharge/transition plan should be amended to include any of the following, if there is a change:
  o MYPAC services begin and end date;
  o Reason for discharge;
  o The name of the person or agency that cares for and has custody of the member;
  o The physical location/address where the member resides;
  o A list of the member’s diagnoses;
  o Detailed information about the member’s prescribed medication(s) to treat their SED including:
    ▪ Medication name;
    ▪ Medication strength;
    ▪ Medication dosage instructions in layman’s language;
    ▪ Any special instructions for the medication, including but not limited to, lab work requirements.
  o Information connecting the member and family with community resources and services, including but not limited to:
    ▪ Address of where follow-up mental health services will be obtained with contact name and phone number;
    ▪ Name and address of the school the member will attend with name and contact information of identified educational staff;
    ▪ Other recommended resources, including recreational, rehabilitative, or other special programs including the corresponding contact information;
    ▪ Date, time and location of any scheduled appointments.
  o Detailed and specific recommendations about the member’s participation in the MUYFAC program including successful techniques in areas of behavior management, mental health treatment and education; and
  o The offer of a full array of community-based mental health services for members.

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)**

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)** services are delivered 24 hours/7 days a week to members under age twenty-one (21) that do not require emergency or acute psychiatric care but do require supervision and treatment on a twenty-four (24) hour basis. The goal of PRTF treatment is to help the individual reach a level of functioning where the least restrictive treatment will be possible.

**Admission Criteria**

• The member does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis.
  AND
• A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges must approve each admission.
  AND
• The member has a psychiatric disorder that is documented by the assignment of an appropriate diagnosis, as per the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
  AND
• The member can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.
  AND
• The member's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.
  AND
• The referring psychiatrist or psychologist advises that residential treatment is needed.
  AND
• At least one (1) of the following:
  o The member has failed to respond to less restrictive treatment in the last three (3) months.
  o Adequate less restrictive options are not available in the member's community.
  o The member is currently in an acute care facility whose professional staff advise that residential treatment is needed.
  o The admission has been certified as medically and psychologically necessary.

**Continued Service Criteria**

• See common criteria
• AND
• Active treatment is being provided to include multidisciplinary diagnostic assessment, interdisciplinary treatment planning, therapeutic intervention, treatment evaluation/revision and discharge and aftercare planning.
  • AND
• Documentation of treatment successes including which goals have been achieved/not achieved.
  • AND
• Updates are made to the treatment plan including the re-assessment of the need for continued residential care or less restrictive care.
  • AND
• Revisions are made to the discharge plan and discharge date as progress is made.

**Discharge Criteria**

• The member has reached age twenty-two (22).
• OR
• PRTF goals have been met.
• OR
• PRTF goals have not been met, the member is transferred to a more restrictive or less restrictive level of care.
• OR
• PRTF goals have not been met, the member or member's guardian chooses to discontinue services.

**Clinical Best Practices**

**Evaluation and Treatment Planning**

• The diagnostic evaluation must document the need for the PRTF level of care.
• Diagnostic evaluations must be completed within the first fourteen (14) days of admission.
• The assessment process must include, but is not limited to, the following:
  o A psychiatric evaluation.
  o A psychological evaluation signed by a licensed psychologist, which must have been completed in the sixty (60) days prior to admission. If no psychological evaluation has been conducted within the last twelve (12) months, one must be completed within fourteen (14) days following PRTF admission.
  o A medical history and examination.
  o A psychosocial assessment, which includes a psychological profile, a developmental profile, a behavioral assessment, and an assessment of the potential resources of the member's family.
  o An educational evaluation.
  o A nursing assessment.
  o A nutritional assessment, if indicated.
• Treatment planning is a collaborative venture in which the members of varying disciplines jointly develop a comprehensive, individualized plan for the treatment of each member.
  o The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible.
An initial treatment plan must be in effect within seventy-two (72) hours after the member’s admission to the facility.

The interdisciplinary treatment team must meet to discuss, approve and implement a more comprehensive treatment plan within fourteen (14) days after the member’s admission, once at the conclusion of the first (1st) month of stay, and once a month thereafter.

The treatment plan document must contain evidence of the member’s and his/her parent/guardian’s active participation in the treatment planning/review/revision process.

- At a minimum, the team must include, either:
  - A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, or
  - A Psychiatric Mental Health Nurse Practitioner (PMHNP) and a physician licensed to practice medicine or osteopathy, or
  - A licensed psychologist and a physician licensed to practice medicine or osteopathy.

- The team must also include one (1) of the following:
  - A licensed certified social worker who has a minimum of one (1) years’ experience in treating children with serious emotional disturbances (SED), or
  - A registered nurse who has a minimum of one (1) years’ experience in treating individuals with SED.

- The treatment plan outlines all aspects of treatment including:
  - Diagnosis
  - An assessment of the member’s immediate therapeutic needs.
  - An assessment of the member’s long-range therapeutic needs.
  - An assessment of the member’s personal strengths and liabilities.
  - Identification of the clinical problems that are to be the focus of treatment.
  - Measurable and realistic treatment goals for each identified problem.
  - Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.
  - Specific treatment modalities and/or strategies that will be employed to reach each objective.

Discharge Planning

- An individualized discharge plan includes:
  - Discharge criteria, indicating specific goals to be met,
  - An estimated discharge target date, and
  - No later than seven (7) days prior to discharge, the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the member.
  - When applicable, a minimum of a seven (7) day supply of each of the member’s medication(s), and a prescription for a thirty day supply of each of the member’s medication(s).

REFERENCES

Mississippi Guidance


Common Criteria and Common Clinical Best Practices


American Association of Community Psychiatrists. Level of care utilization system (LOCUS) for psychiatric and addiction services: Adult version 2010.


REVISION HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
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<tbody>
<tr>
<td>05/09/2018</td>
<td>• Combined previously separate LOCGs into one document</td>
</tr>
<tr>
<td>10/1/2018</td>
<td>• Added new MYPAC and PRTF guidelines</td>
</tr>
</tbody>
</table>

The Mississippi Medicaid Provider Reference Guide defines “Serious Emotional Disturbance” as a diagnosable mental disorder found in youth that is so severe and long lasting that it seriously interferes with functioning in family, school, community or other major life activities, Public Law 103231 states that: “The resulting definition of SED requires children to have a psychiatric diagnosis (excluding V codes, substance abuse, and developmental disorders occurring in the absence of another diagnosable disorder) and substantial impairment in family, school or community activities. Adding an impairment indicator was meant to distinguish between children with psychiatric disorders that significantly affected their ability to function in their environment and those having only mild impairments.”

The Mississippi Medicaid Provider Reference Guide defines “Serious Emotional Disturbance” as a diagnosable mental disorder found in youth that is so severe and long lasting that it seriously interferes with functioning in family, school, community or other major life activities, Public Law 103231 states that: “The resulting definition of SED requires children to have a psychiatric diagnosis (excluding V codes, substance abuse, and developmental disorders occurring in the absence of another diagnosable disorder) and substantial impairment in family, school or community activities. Adding an impairment indicator was meant to distinguish between children with psychiatric disorders that significantly affected their ability to function in their environment and those having only mild impairments.”