Multi-Systemic Therapy (MST)
Request for Service Limit Override

Instructions

Item A: All criterions, 1-5 must be checked for override consideration. Item B: Must be completed by the MST Team Supervisor. Item C: Must be completed by the MST Expert. Once all items are completed and signed, forward along with a copy of the MST Service Log/documentation, attachments, and the completed CMS 1500 Claim Form(s) to the address below. You will be notified by fax of the decision.

DHH/BHSF/Medicaid Behavioral Health Section
Attn: SAA Unit
P.O. Box 91030
Baton Rouge, LA 70821-9030

A. MST Therapist and/or Supervisor Only

Documentation supporting the following continuing treatment criteria must be submitted for requests to override the service limit:

☐ **Criterion 1:** Treatment does not require a more intensive level of care (*include specific reason why additional units are necessary*);

☐ **Criterion 2**: The treatment plan has been developed, implemented, and updated based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated (*include specific goals accomplished)*;

☐ **Criterion 3:** Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident (*include specific goals to be accomplished*);

☐ **Criterion 4:** The family is actively involved in treatment or there are active, persistent efforts being made which are expected to lead to engagement in treatment (*provide evidence of family consensus for additional services*) and;

☐ **Criterion 5:** There is documented evidence of active, individualized discharge planning (*include proposed extension time period*).

Attachments
1. Psychiatric, psychological or psychosocial evaluation;
2. Updated treatment plan with specific and individualized interventions; and
3. Most current weekly review (case summary for supervision & consultation).

Multi-Systemic Therapy (MST)
Request for Service Limit Override

*This information must be printed.

MST Supervisor: _____

Team: _____

MST Therapist: _____

Client Family: _____

Date services initiated: _____ Date additional units requested: _____

Agency Fax #: _____
(Include area code)

Rationale for Treatment Extension: _____

_____

B. MST Supervisor Only

Justification for criterions 1-5 (refer to section A):

Specific reason why extension is necessary: _____

_____

_____

Specific goals to be accomplished: _____

_____

_____

_____

Evidence of family consensus for extension: _____

_____

_____

_____

Proposed extension time period: _____ # of units requested: _____

Signature: _____ Date _____

Printed Name/Title: _____ Phone: _____

Multi-Systemic Therapy (MST)
Request for Service Limit Override

C. MST Expert Use Only

Anticipated discharge date: _____

Recommendations regarding extension: _____

_____

_____

_____ # units: _____

Signature: _____ Date _____

Printed Name/Title: _____ Phone: _____

D. DHH/MBHS Use Only

Approved: _____ # units: _____ Denied: _____

Reviewed by:

_____ _____ (Name/Title)
Date

_____ _____ (Name/Title)
Date