APPENDIX 4

MULTISYSTEMIC THERAPY (MST)

Service Definition

Multisystemic Therapy (MST) is an intensive family and community-based, evidence-based treatment which addresses the externalizing behaviors of youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST is provided using a home-based model of service delivery for youth and families, targeting youth between the ages of 12 - 17 who are at high risk of out-of-home placement or justice system involvement, or who may be returning home from a higher level of care. [Exceptions may be requested for youth ages 10, 11, or 18; admission of such youth must be approved by the MST team supervisor and MST consultant]. MST is delivered in the natural environment (e.g., home, school, community) with the treatment plan designed in collaboration with the youth, family, and all relevant child-serving systems (e.g., DJJ, DSS, Mental Health, and/or other SC child-serving agencies, the school district, faith-based organizations, etc.).

MST includes engagement with the youth's family, caregivers, and natural supports, as well as professionals delivering interventions in the recovery environment. MST is an intensive but short-term service, effecting change, on average, within ***four months (120 days) of treatment*** and ***60 hours of intervention***. This culturally-sensitive rehabilitative service may also serve as a step-down or diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and neighborhood/community.

Critical Components of the MST Model

Critical Components of MST include the following:

- Integration of evidence-based therapeutic interventions to address a comprehensive range of risk factors across family, peer, school, and community contexts;
- Promotion of behavioral change in the youth's natural environment, with the overriding goal of empowering caregivers with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school, and neighborhood problems;
- Rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change; and

- MST providers who are on call 24 hours/day, seven days/week to provide safety planning and crisis intervention.

MST is based on the philosophy that the most effective and ethical way to help children and youth is by helping their families. MST views caregivers as valuable resources, even when many of them have serious and multiple needs of their own. One primary goal of MST is to empower caregivers to effectively parent their children. MST reaches across all of the youth's life domains and is highly individualized for each case.

MST providers may deliver the therapeutic interventions involved in a range of community settings, such as the youth's home, school, homeless shelters, libraries, etc. MST includes therapeutic intervention and care coordination to assist the youth in meeting their specific goals.

Therapeutic interventions and collateral contacts may range from brief check-ins to more intensive sessions lasting up to two-hours or more. The required supervision, professional consultation, and monitoring provided through the evidence-based model work to uphold treatment fidelity expectations around service delivery intensity and frequency.

Frequency, Intensity, and Duration

MST providers deliver this service primarily in person with the youth and their natural supports, in locations outside of a clinic or facility. MST sessions are tailored by an MST Service Plan. Service intensity varies with the needs of the youth and family/caregiving system. Early in treatment, the MST provider may meet with the family several times a week, but as treatment progresses, intensity typically tapers. The frequency of therapeutic interventions is flexible and based on clinical need, allowing the service to be responsive to periods of crisis or high risk and to decrease the intensity for families with lower levels of need. The MST model expects the MST provider to take the lead in coordinating care while youth are participating in MST services.

The frequency, intensity, and duration of MST services is dependent on the needs of the youth as described in the Service Plan:

- If not in conflict with the MST Service Plan for a particular youth, the MST model expects an average of 10-20 therapeutic interventions within the first month *but shall ultimately be tailored to the needs of the youth.*
- These initial therapeutic interventions typically occur multiple times per week in frequency. For the second and third months of MST, an average of 8 to 12 therapeutic interventions typically occur each month, though *will vary based on the needs of the youth.*
- The MST model expects that service frequency typically will be tapered over the duration of the treatment period based on the youth's needs and the family's adaptation to the new skills in use. Close to treatment termination, the MST provider contacts the family as needed to ensure that treatment gains have been sustained by the family.

NOTE: These numbers do not represent definitive guidelines for MST service provision; rather, they illustrate the standard course of an MST episode of care. These numbers are not to be used as quality assurance or productivity metrics.

Service Components Documentation

Service components of MST include:

- Assessment
- Service Planning
- Therapeutic interventions
- Crisis intervention, and
- Care coordination

Assessment

At the start of services, a Licensed Practitioner of the Healing Arts (LPHA; as described in Section 3, *Eligible Providers*) shall conduct an initial assessment consistent with the components required in the Diagnostic Assessment (see page 83 for service description), documenting the youth's diagnosis(es) and describing how service needs match the level of care criteria.

Service Planning

MST Service Plans shall guide the course of treatment and remain current to the identified needs of the youth and family. Service plans must be completed, signed, dated, and in the medical record within 30 days of the start of services.

The treatment planning process should be collaborative but must be authorized by the MST Supervisor. In cases where the MST provider is not independently licensed, the MST Supervisor directs and authorizes the treatment planning process as part of the MST model.

MST Service Plans must be reviewed as necessary at a minimum of every 30-calendar days or more frequently depending on the youth’s needs. These 30-day reviews are consistent and comply with the routine activities required for fidelity to the MST model and include treatment team meetings, consultations with MST supervisors and consultants, meetings with youth and natural supports, and administration of fidelity measures.

MST Service Plan Development Requirements

MST therapists are required to create a Service Plan for each family. This plan will incorporate the desired outcomes of the key participants/stakeholders involved in the family’s treatment (e.g., parents, probation, social services, school personnel, etc.). This plan shall be sent to the referring agency caseworker/case manager, and a copy of the Plan will be placed in the youth’s individual file.

The Service Plan will identify family/client strengths, help the family/client define specific goals, provide instruction in ways to prevent the recurrence of delinquent behavior and other family

conflict, and set up resources and skills to maintain ongoing progress. Additionally, the Service Plan will:

- Identify the multiple determinants of antisocial or maladaptive behavior for each case.
- Identify and document the strengths and needs of the adolescent, family, and the extra-familial systems (e.g., peers, school, neighborhood, etc.).
- In collaboration with family members, identify and document problems throughout the family and extra-familial systems (e.g., peers, school, neighborhood, etc.) that explicitly need to be targeted for change.

The MST supervisor must review and approve all service plans.

Therapeutic Interventions

MST therapists provide a range of goal-directed services to each client/family that may include but shall not be limited to:

- Improving parenting practices;
- Increasing family affection;
- Decreasing association with deviant peers;
- Increasing association with pro-social peers;
- Improving school/vocational performance;
- Engaging youth/family in positive recreational activities;
- Improving family/community relations;
- Empowering family to solve future difficulties;
- Teaching appropriate parenting skills, such as:
  - Alternatives to corporal punishment
  - Appropriate supervision of children
  - Age-appropriate expectations
  - Choices and consequences
  - Displays of greater parent/child affection and trust;
- Family and marital interventions consistent with MST principles;
- Individual interventions for parents and youth consistent with MST principles;
- Aiding the family in meeting concrete needs such as housing, medical care and legal assistance and assisting in making available follow-up support resources as needed;
- Teaching the family organizational skills needed to provide a positive environment (e.g. teaching budgeting skills, etc.);
- Referring and linking the family with follow-up services when necessary to ensure continued success meeting the family's MST treatment goals;
- Transporting youth/family when necessary and facilitating family plans to access transportation themselves on an ongoing basis;
- Providing services in the client's home, or, at the client's request, at a location mutually agreed upon by the therapist and client; and
- Assessing for and managing substance use issues and providing specialized interventions such as contingency management, as necessary.

Crisis Intervention

Crisis intervention services must be available 24 hours per day, seven days per week, 365 days per year to youth and families receiving MST and provided by a member of the MST team. Crises may be managed in person or telephonically, based on clinical need, by the assigned MST provider, an on-call MST provider, or the MST team supervisor (or MST supervisor on-call).

Crisis services shall be billed using the MST procedure code, H2033.

MST Documentation Requirements

Documentation must relate to the goals of the MST Service Plan and should be completed for each therapeutic intervention or collateral contact; however, the bulk of ongoing clinical documentation for regularly scheduled MST sessions should be provided in the *MST Weekly Case Summary*.

Service notes for planned MST sessions may be brief and utilize references to goals and interventions by goal/objective number (corresponding to the formatted list of goals/objectives on the Service Plan), **as long as** the MST Weekly Case Summary provides adequate clinical detail to summarize goals that were addressed in the week's sessions, interventions provided, response of the youth/family, and overall treatment progress/status of youth/family for each session.

In summary, it must be clearly identifiable to an independent reviewer of the youth's record that a service was provided for each date an MST claim was billed. Each per diem billed must correspond to the MST Weekly Case Summary, documented in chronological order, with the level of clinical detail and narrative necessary to warrant the number of per diems billed.

NOTE: This does not apply for crisis intervention services, which must be documented independently on a clinical service note and include identified risks, interventions provided, client response, and safety planning.

All documentation for services rendered, including that which is specific to the MST model, must be included in the youth's individual record. It is permissible to utilize any MST format or template for documentation; as long as there is evidence of ongoing clinical intervention adequately covered in each submission, this documentation will serve as the requirement for Healthy Connections Medicaid.

Medical Necessity

Admission Criteria: Diagnosis, Symptoms, and Functional Impairment

Youth must meet *all* of the following criteria for admission to MST:

1. The youth must be between the ages of 12 and 17. [Exceptions may be requested for youth ages 10, 11, or 18; approval must be provided by the MST supervisor and/or MST consultant].
2. The Diagnostic Assessment completed by an LPHA demonstrates evidence of symptoms and functional impairment that the youth meets criteria for a primary diagnosis that falls within the categories of disruptive behavior disorders, mood, substance use, or trauma and stressor-related disorders, consistent with the most recent version of the Diagnostic and Statistical Manual (DSM). Those with other primary behavioral health diagnoses that may benefit from the interventions of MST may be considered on a case-by-case basis under EPSDT.
3. Within the past 30 calendar days, the youth has demonstrated at least **one** of the following that puts the youth at risk of out-of-home placement:
    a. Persistent and deliberate attempts to intentionally inflict serious injury on another person.
    b. Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of actions that are endangering to self or others, are difficult to control, cause distress to the youth or others, or negatively affect the youth's or others' health and well-being; this criterion may include a pattern of oppositional or defiant behavior, delinquency, or previous or current involvement with law enforcement or the juvenile justice system.
    c. Increasing and persistent symptoms associated with depression (e.g., chronic irritability, anhedonia, significant changes in sleep/eating, emotion regulation disturbances, etc.) or anxiety (e.g., rumination, panic attacks, hypervigilance, dissociation, etc.), **in combination with externalizing issues** (e.g., physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the home, school, and/or community.
    d. Ongoing substance use or dependency that interferes with the youth's interpersonal relationships and functioning in the home, school, and/or community.
    e. The youth is returning home from out-of-home placement or an institutional setting (such as DJJ); ***or***
    f. MST is needed as a step-down transition from an out-of-home placement or an institutional setting.
4. The youth's successful reintegration to or ability to maintain in the home and community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the MST model. Participation in an alternative community-based service would not provide the same opportunities for effective intervention and rehabilitation of the youth's problem behaviors.
5. There is a family member or other committed caregiver available to participate in this intensive service for the duration of the model intervention.
6. Arrangements for supervision at home/in the community are adequate to ensure a reasonable degree of safety, and a safety plan has been established (or will be quickly established) by the MST provider as clinically indicated.

Exclusion Criteria

Youth who meet any **one** of the criteria below are **not** eligible to receive MST:

1. The youth is currently experiencing active suicidal or homicidal behavior (i.e., not transient ideation), or psychotic processes that require continuous supervision that is NOT available through the provision of MST, and/or the youth's psychiatric problems are the primary reason leading to referral.
2. The youth is living independently, or the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult supports, or other potential surrogate caregivers.
3. The youth's presenting problem is limited to sexually harmful or dangerous behavior *in the absence of* other externalizing behaviors.
4. The youth's functional impairment is solely a result of intellectual or developmental disability, or the youth has moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism or other similar disorder.

Criteria for Continuing Services: Diagnosis, Symptoms, and Functional Impairment

High-fidelity implementation of MST requires that teams aim for average episodes of care from three to five months; nearly all families (with few exceptions) complete MST treatment in five months. Likewise, rarely are youth re-referred to MST after discharge from the program – although this is possible, it is generally only in circumstances where the youth's entire ecology has changed and problems have resurfaced in that new ecology (ex., a youth has changed schools and neighborhoods and is now engaging in apparent gang activity). Therefore, while MST does not limit a youth from re-entering MST services, the case would be substantially reviewed by the MST supervisor and/or MST consultant prior to accepting the referral.

MST services beyond the standard episode of care are allowable in certain circumstances, as outlined below. Within the past thirty (30) calendar days, MST continues to be the appropriate level of care for the youth as evidenced by at least ***one*** of the following:

1. The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria.
2. The youth has manifested new symptoms/behaviors that meet admission criteria and those have been documented in the MST Service Plan.

   and/or
2. Progress toward identified goals is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goals have been achieved.

Requests for approval of continuing services must be approved and require documentation demonstrating active treatment and care coordination. Requests must include ***all*** of the following:

- An MST Service Plan with evaluation and treatment objectives appropriate for this level of care and type of intervention. The treatment must support objectives for community integration, including the development of the youth's network of personal, family, and

community support. Treatment objectives are related to readiness for discharge and MST-specific expected outcomes;
- Progress toward objectives is being monitored with fidelity to the model as evidenced in the 30-calendar day Service Plan review documentation;
- The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement;
- The type, frequency, and intensity of interventions are consistent with the MST Service Plan and maintain fidelity to the model;
- The provider is making vigorous efforts to affect a timely transition to an appropriate lower level of care than that of the intensity and frequency of a service such as MST. These efforts require documentation of discharge planning beginning at the time of admission to include communication with service practitioners, community partners, and natural supports that will meet the needs of the client;
- The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care but requires additional time to implement the plan.

Utilization Management. Documentation of the request for service extension must be provided on the Request for Approval of Continued MST Services form (found in the RBHS provider manual Forms section) and signed by the MST Supervisor and MST consultant. Continued service requests are approved by the SCDHHS Office of Behavioral Health. The form should be attached to the first claim submitted after all initial (48) per diems are exhausted; the claim with attachment must be submitted via the Medicaid web tool. Questions or other inquiries may be submitted to MedicaidStatePlan@scdhhs.gov. Additional documentation may be requested as necessary.

If the youth does not meet criteria for continued treatment, MST may still be authorized by SCDHHS Office of Behavioral Health for (up to) an additional 10 calendar days under any of the following circumstances:
- There is no less intensive level of care in which the objectives can be safely accomplished; ***or***
- The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; ***or***
- The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.

Discharge Criteria

The youth meets discharge criteria if any of the following are met:
- The youth's documented MST Service Plan goals have been met, and the discharge plan has been successfully implemented;
- The youth and family are not engaged in treatment despite documented efforts to engage them in services and there is no reasonable expectation of progress at this level of care;

- The youth is placed in an out-of-home placement, including but not limited to, a hospital, skilled nursing facility, psychiatric residential treatment facility, institutional setting (such as DJJ), or therapeutic group home and will not be ready for discharge to a family home environment or a community setting with community-based support within 31 consecutive calendar days;
- Required consent for treatment is withdrawn; ***or***
- There is a lapse in services greater than 31 consecutive calendar days.

Provider Qualifications, Staff Requirements, and Training Requirements

MST teams must be licensed through MST Services, Inc. and maintain active program certification. This means that all providers operating within an MST team must complete training as outlined and required by the model and maintain the standards of MST service provision with fidelity to the model. MST providers should not have split caseloads when working for an organization (i.e., they should be dedicated to provision of MST).

The MST team composition includes an MST supervisor and a minimum of two to a maximum of four MST therapists. Both team supervisor and team therapists participate in a rotating schedule of coverage so that an MST-trained team member is available 24 hours per day, seven days per week, year-round for crises.

MST supervisors must be LPHAs ***or*** master's level clinicians with two years of experience as an MST therapist. LPHAs must have at minimum a master's degree in psychology, social work, counseling, or a related field, and independent licensure in their identified discipline (i.e., licensed psychologist, LISW-CP, LPC, LMFT, or LAC). MST supervisors must attend additional training on MST supervision before managing an MST team.

MST therapists must have a master's degree in psychology, social work, counseling, or a related field, ***or*** a bachelor's degree in psychology, social work, counseling, or a related field plus two years of experience working with families.

NOTE: The term "therapist" is in keeping with the nomenclature of this evidenced-based practice. Where providers are intended to be LPHAs who render counseling and psychotherapy under the respective scope of practice defined by their SC license, it is designated as such.

A full-time MST supervisor may clinically oversee:

- A single MST Team; or
- Two MST teams in the same geographical area; or
- One MST team and provide MST services to one or two youth (exceptions may be made during times of staff transition within the team, which may require the supervisor to take on more than two cases; any additional cases assigned to the supervisor must be in accordance with the MST consultant's guidance and approval).

An MST therapist maintains an average caseload of four to six youth. MST therapists provide direct intervention and also arrange, coordinate, and monitor services on behalf of the youth.

The MST model requires that all MST team members participate in weekly MST-specific group supervision sessions facilitated by the MST supervisor per MST model standards. MST team members also must participate in weekly MST-specific telephone consultations provided by MST Services, Inc., or a licensed MST Network Partner training organization (which can be found on the MST Services, Inc website at https://www.mstservices.com/), with no more than six weeks per year without consultation (i.e., due to the occurrence of quarterly trainings and/or holidays, etc.).

MST therapists and MST supervisors must attend all required training. This training will include both pre-service and ongoing in-service training and consultation.

Training and consultation for clinical staff shall be provided in three ways:

1. MST Orientation and Initial Training -- Intensive orientation training through MST Services, Inc. is required for all staff who will engage in treatment and/or clinical supervision of MST cases. This includes 20 hours of eLearning and two days of in-person training sessions.
2. All MST staff must attend one and one-half (1½) day booster sessions on a quarterly basis.
3. Treatment teams and their supervisors must participate in weekly telephone consultation provided by trained MST consultants.

The objectives of MST orientation and initial training are to:

- Familiarize therapists with the theoretical, empirical, and clinical paradigms underlying the MST model and help them begin to incorporate those paradigms into their work.
- Familiarize therapists with the scope, correlates, and causes of serious behavior problems addressed by MST.
- Describe the theoretical and empirical basis for MST.
- Describe common family, peer, school, individual, and social support assessment and intervention strategies used in MST.
- Teach therapists to conceptualize cases and interventions in terms of the MST principles.
- Teach therapists to use the Do-Loop to conceptualize cases and design and implement interventions.
- Describe strategies MST teams use to build strong, collaborative relationships with stakeholder agencies in the community.
- Describe MST therapists' role in continuous quality improvement.
- Provide therapists with opportunities to practice using MST assessment strategies and interventions.

The multi-media approach to training includes didactic and experiential components. The participants are required to practice the MST approach through critical analysis, problem solving

exercises, and role-plays. It is expected that participants will have read the MST treatment manual (textbook) prior to the initial training.

Fidelity Measures

Fidelity measures for MST are required components for all MST teams. Quality assurance support activities focus on monitoring and enhancing program outcomes through increasing therapist adherence to the MST treatment model. The MST Therapist Adherence Measure (TAM) and the MST Supervisor Adherence Measure (SAM) have been validated in the research on MST with antisocial and delinquent youth and are now being implemented by all licensed MST programs. Both measures are available through the MST Institute.

An overview of the MST Quality Assurance Program can be found at the MST Institute.

Required Quality Assurance Program components include the following:

- Register the program and all staff at the MST Institute
- Register each family engaged in MST at the MST Institute secure website using HIPPA approved procedures.
- Complete discharge summaries on all families and close out each discharged family on the MST Institute secure website.
- Complete yearly evaluations of team members to assess knowledge of and compliance with MST philosophy and intervention strategies. MST adherence data may be used as part of this team member evaluation.
- Monitor the adherence of program staff to the MST model by collecting the MST Therapist Adherence Measure-Revised (TAM-R) data as specified by MST Services. In addition, MST therapists are required to complete the MST Supervisory adherence Measure (SAM) at least every other month by logging on directly to the MST Institute website.

The Therapist Adherence Measure Revised (TAM-R) is a 28-item measure that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. The adherence scale was originally developed as part of a clinical trial on the effectiveness of MST. The measure proved to have significant value in measuring an MST therapist's adherence to MST and in predicting outcomes for families who received treatment. More information is available at the MST Institute

The Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists. The measure is based on the principles of MST and the model of supervision presented in the MST Supervisory Manual. More information is available at the MST Institute.

Billing Guidance

MST is provided under the CMS-approved HCPCS procedure code for Multisystemic Therapy (H2033). MST includes a bundled service rate, which takes into account indirect costs such as meetings, travel time, training, supervision, documentation, fidelity reviews, etc., in the

development of reimbursement. Based on what constitutes a therapeutic "dose" of MST and the expected course of treatment as per the MST model, service units are structured as a per diem, organized in the following way to offer flexibility in service provision:

- Providers are allowed 48 per diems over a period of 120 days (4 months);
- These units may be used with any frequency to meet the intensity level required based on the youth/family's needs.
- Only one per diem per youth/family may be billed per day.

The initial 48 per diems do not require prior authorization.

Additional per diems may be approved if substantiated by the appropriate documentation (see Criteria for Continuing Services, above).

In-person or telephonic service time between the provider and youth or family may be billed when geared towards specific goals on the MST Service Plan; the youth is not required to be present, and in fact, most sessions will take place between the caregiver(s) and the provider.

In-person or telephonic service time between the provider and collateral contacts are billable to Medicaid using procedure code H2033 under the following conditions:

- Contacts involve other professionals (i.e., school personnel, probation officers, or other child-serving agencies) with a vested interest/relationship with the child receiving treatment.
- Contacts are based on goals from the youth's plan of care.
- The youth or family may be present during the contact or otherwise aware of and/or engaged in the contact.

Service Limitations and Exclusions

MST **may not** be provided concurrently with the following services*:

- Group or Family Therapy.
- Any other type of Intensive In-Home Services.
- Outpatient or inpatient substance use disorder services, *except for opioid use disorders.*
- Partial Hospitalization or Intensive Outpatient Programs.
- Inpatient psychiatric hospitalization or PRTF.

**Other family members may be receiving one of the above services and still participate in MST as appropriate for the benefit of the youth receiving MST services.*

No other RBHS services are allowable during the course of MST with the exception of the following:

- Psychological Testing/Evaluation.
- Medical Evaluation and Management/ Psychiatric Medical Assessment.
- Medication Management/Nursing Services.
- Individual Psychotherapy (***ONLY*** when indicated and medically necessary).+

+ If the youth continues to meet with an existing outpatient therapy provider (or requires a referral to a provider outside of the MST service) for specific treatment needs outside the scope

of MST (ex., is receiving or needs referral for Trauma-Focused Cognitive Behavioral Therapy or another EBP for trauma), the MST provider must coordinate the treatment plan with the outpatient provider. The MST Supervisor and/or MST Consultant must be aware of and approve the proposed split in services when additional therapeutic adjuncts are necessary. Documentation describing the clinical rational and approval of the outside services must be included in the youth's record.