



**MEDICAL NECESSITY CRITERIA
INDIVIDUAL RESIDENTIAL TREATMENT (IRT)/COMMUNITY
RESIDENTIAL REHABILITATION (CRR) HOST HOME/THERAPEUTIC
FOSTER CARE (TFC)¹**

**SECTION I: INDIVIDUAL RESIDENTIAL TREATMENT (IRT)/COMMUNITY
RESIDENTIAL REHABILITATION (CRR) HOST HOME/THERAPEUTIC
FOSTER CARE MEDICAL NECESSITY CRITERIA**

All of the following criteria in Sections 1 and 2 must be met for admission to an IRT/CRR Host Home/TFC

1. A Best Practice (BP) evaluation following the Life Domain Format for Psychiatric/Psychological Evaluations, 2nd edition, as defined by Dr. Hodas in the *Guidelines for Best Practice in Child and Adolescent Mental Health Services, Copyright 2001*, must be completed by a psychiatrist or a licensed psychologist prior to admission; **and**
2. The strengths-based BP evaluation must identify strengths of the child, family, community, and natural resources; **and**
3. The BP eval documents an Axis I Diagnosis (MR or D&A cannot stand alone); **and**
4. The BP eval indicates that, due to severe mental/emotional illness and/or a behavioral disorder, a 24-hr/day structured environment is necessary for the child/adolescent to support his/her efforts to meet basic needs, utilize appropriate judgment, coping skills and comply with treatment. (24-hr supervision and observation may be provided by the Host Home family or professional staff from the IRT/CRR Host Home/TFC in this setting as needed); **and**
5. The BP eval indicates that IRT/CRR Host Home/TFC is the most appropriate and least restrictive level of care to meet the mental health needs of the child; **and**
6. If the child/adolescent has been involved in specialized treatment services, he/she has received treatment and symptoms have stabilized; and the child/adolescent is able to access continuing specialized mental health or drug and alcohol treatment services as needed while in this level of care; **and**
7. The child/adolescent is under the age of 21; **and**
8. The risk of safety to self and others is manageable in the community; **and**
9. The child needs services and support in order to function in the community; **and**
10. The parent/guardian and child are involved in the treatment planning process and agreeable to participate in IRT/CRR Host Home/TFC treatment; **and**
11. A less restrictive treatment setting has been provided and/or has been considered and reasons for its rejection have been documented, or the child is being discharged from

¹ IRT/CRR Host Home/TFC is sometimes referred to as CRR Group Home.

a higher level of care and needs treatment in a IRT/CRR Host Home/TFC to obtain or sustain gains or to prevent further deterioration of symptoms. The child's behavior cannot be safely maintained in a lower level of care; **and**

12. The ISPT recommends IRT/CRR Host Home/TFC as the least restrictive and most clinically appropriate service for the child; **and**
13. The ISPT develops realistic and achievable treatment goals and discharge criteria for the child/adolescent and family; **and**
14. The ISPT must include the following participants:
 - a. the parent/legal guardian and child (if age 14 or older); **and**
 - b. the host home parent(s) for the Continued Stay Review(s); **and**
 - c. a representative from the child's home school district for the initial ISPT and from the host home school district for the Continued Stay Review(s); **and**
 - c. ICM/RC or county case manager

SECTION II: SYMPTOMS SEVERITY FOR ADMISSION AND CONTINUED STAY

1. The child's problematic behavior and/or severe functional impairment as indicated in the Best Practice Life Domain Psychiatric Evaluation must include at least one of the following:
 - a. suicidal/homicidal ideation
 - b. dangerous risk-taking behavior
 - c. aggression
 - d. psycho-physiological condition (i.e., an eating disorder)
 - e. psychomotor retardation or excitation
 - f. affect/function impairment (i.e., withdrawn, reclusive, labile, reactivity)
 - g. psychosocial functional impairment
 - h. thought impairment (i.e., psychosis)
 - i. cognitive impairment related to the child's psychiatric condition; **and**
2. The child demonstrates exacerbation or continues to display severely impaired judgment or functional capacity and capability (i.e., interpersonal skills and/or self-maintenance is severely compromised); **and**
3. If there is risk of harm to self, others, or property, the child with host home family and parent/guardian/caregiver develop and sign a safety plan; **and**
4. The child's treatment needs cannot be appropriately met in the current living environment(s), i.e.,
 - a. home, even if services were delivered in the home/community, and/or
 - b. RTF or inpatient unit because a less intensive/restrictive setting is needed for a step-down or transition; **and**
5. The child/adolescent is able to function and participate safely in age-appropriate, community-based activities for limited periods of time with appropriate supervision and support; **and**
6. Commitment to treatment by primary caregivers and child is documented

SECTION III: EXCLUSION CRITERIA FOR ADMISSION AND CONTINUED CARE

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

1. The child/adolescent currently exhibits severe suicidal or homicidal threats/attempts, acute mood symptoms, active psychosis, dangerous behavior or significant cognitive impairment which requires a more intensive level of behavioral health care; **or**
2. Child/adolescent has primary acute substance abuse problems requiring residential D & A treatment; **or**
3. The child/adolescent has medical conditions or impairments that prevent participation in services and/or require daily care that is beyond the usual program scope

SECTION IV: IRT/CRR HOST HOME/TFC CONTINUED STAY CRITERIA
All of the following criteria in Sections 2 and 4 must be met for continued stay in an IRT/CRR Host Home/TFC

1. Initial diagnosis and evaluation is updated and revised as a result of a face-to-face BP evaluation by the treating psychiatrist or psychologist and the child/adolescent's special needs continue to meet medical necessity criteria at this level of care; **and**
2. Less restrictive treatment environments have been considered in consultation with the ISPT, and the ISPT recommends IRT/CRR Host Home/TFC as the least restrictive/intrusive and most clinically appropriate service for the child; **and**
3. Continued active intervention in IRT/CRR Host Home/TFC is likely to be of substantial benefit in achieving discharge goals; **and**
4. The symptom severity and updated treatment plan supports the likelihood that:
 - a. substantial benefit is expected as a result of continued active intervention in a IRT/CRR Host Home/TFC setting w/o which there is great risk of a recurrence of symptoms; **or**
 - b. Axis I symptom severity is such that treatment cannot be safely delivered at a lesser level of care (MR and D & A symptoms cannot stand alone); **and**
5. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes as described in the treatment plan; **and**
6. Service providers document efforts at least weekly to engage parent/legal guardians or discharge caregivers in the treatment process; **and**
7. There is documented active discharge and aftercare planning with the child and discharge caregivers; **and**
8. The ISPT review recommends continued stay and documents the need for further improvement, with the corresponding modifications in both the tx plan and discharge goals; **and**
9. ONE OF THE FOLLOWING MUST ALSO BE MET:
 - a. Further progress must occur before transition to a lesser level of care is advisable; **or**
 - b. Symptoms or behaviors that required admission continue with sufficient acuity that a lower level of care would be insufficient to stabilize the child's condition; **or**
 - c. New symptoms meeting admission criteria have appeared

SECTION V: IRT/CRR HOST HOME/TFC DISCHARGE CRITERIA

Any one of the following can be met for discharge from an IRT/CRR Host Home:

1. The child/adolescent no longer meets Continued Stay Criteria for IRT/CRR Host Home/TFC (Section 2 and 4); *or*
2. Consensus is reached among all treatment team members that treatment plan goals and objectives have been substantially achieved and the child/adolescent is able to function with a less intensive level of care; *or*
3. The child exhibits severe disruptive or dangerous behavior which may include, but is not limited to, suicide or homicide attempt, symptoms of psychosis, drug addiction, fire setting, or sexual offending, requiring immediate attention in a more intensive level of care or an alternative placement with another child serving system; *or*
4. Child/adolescent's discharge criteria have been met and aftercare plan has been activated; *or*
5. Progress is not being made towards treatment goals and/or discharge criteria and there is no reasonable expectation of progress at this level of care (for example, the child/adolescent is unwilling to participate in treatment offered at this level of care); *or*
6. Parent/guardian or an adolescent who can legally consent requests termination of services, because of belief that service goals and objectives have been substantially achieved; *or*
7. Parent/guardian or an adolescent who can legally consent indicates the intention to terminate services despite efforts by the treatment team to address treatment concerns.