Clinical Policy: Multi-Systemic Therapy (MST)

Reference Number: LA.CP.BH.521c
Date of Last Revision: 10/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth. MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, if the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment. By maintaining the youth within the community, the least restrictive environment, MST treatment interventions strengthen the family and youth's relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. Also, the MST model is strengths-focused and competency-based in its treatment approach. The general goal of MST is to promote increased emotional and social health in youth and families.

Policy/Criteria

It is the policy of Louisiana Healthcare Connections Multi-Systemic Therapy is **medically necessary** when the following criteria are met:

I Admission criteria for MST services must be met and the Member is identified as a Target Population. MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, if the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment:

- **A** Referral/target ages of 12-17 years.
- **B** Exhibits significant externalizing behavior, such as chronic or violent juvenile offenses.
- **C** Is at risk for out-of-home placement or is transitioning back from an out of home setting

D Externalizing behaviors symptomatology, resulting in a DSM-5 diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (oppositional defiant disorder, other disruptive, impulse-control, and conduct disorders, etc.)

E Ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems

F Less intensive treatment has been ineffective or is inappropriate

G Treatment planning team or Child Family Team (CFT) recommends that he/she participate in MST.

II. Admission to MST services ***may not*** be clinically appropriate for youth who meet the following conditions:

A Referred primarily due to concerns related to suicidal, homicidal, or psychotic behavior

B Living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, or other potential surrogate caregivers

C The referral problem is limited to sexual offending in the absence of other delinquent or antisocial behavior

D Have moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;

E Low-level need cases

F Have previously received MST services or other intensive family- and community-based treatment

1. Exception-Youth may be allowed an additional course of treatment if all of the following criteria are met:
    a. MST program eligibility criteria are currently met
    b. Specific conditions have been identified that have changed in the youth's ecology, compared to the first course of treatment
    c. It is reasonably expected that successful outcomes could be obtained with a second course of treatment
    d. Program entrance is subject to prior authorization by LHCC

III. Criteria for Continuing MST Services- all must be met.

A Treatment does not require more intensive level of care

B 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.

C 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

D The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

IV. Youth who meet the following criteria no longer meet medical necessity criteria for MST and shall be discharged from MST treatment:

A Treatment plan goals or objectives have been substantially met.

B Meets criteria for a higher or lower level of treatment, care or services.

C Family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment

D Consent for treatment has been withdrawn, or youth and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment

V. The following criteria are excluded from coverage:

A LHCC will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs). These are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions.

B MST services are comprehensive of all other services, except for psychological evaluation or assessment medication management and Coordinated System of Care (CSoC) waiver services. These services may be provided and billed separately for a member receiving MST services.

C MST shall not be billed in conjunction with the following services:

1. BH services by licensed and unlicensed individuals, with the exception of medication management, assessment and CSoC waiver services and/or

2. Residential services, including professional resource family care.

VI Documentation of an Individualized Treatment plan for the youth and family must be submitted with all required elements. All treatment planning will be informed by an initial psychosocial assessment, which is completed by the MST supervisor prior to entry into MST services. Use of the Child and Adolescent Level of Care Utilization System (CALOCUS) is not required for MST. In the MST model, the MST therapist conducts treatment planning using the MST "Case Summary" process; for a member receiving MST services, the document titled "Initial Case Summary," and the documents which are updated each week as the "Weekly Case Summary," serve as the treatment plan for the member. The Initial Case Summary is developed by the MST therapist, based on the assessment, youth and family strengths, referral behaviors, and the goals of the youth and family. Goals of the youth, family, and other key participants in treatment (e.g, probation officer) are documented in the Case Summary as "Desired Outcomes of Key Participants," and these inform the "Overarching Goals" of treatment as documented in the Case summary.

A The Initial Case Summary is signed by the caregiver, and ideally signed by the youth as well. In the rare event that an MST treatment episode is extended for over 180 days, the MST provider must obtain additional caregiver and youth signatures on the updated Case Summary at that time.

B The Initial Case Summary is developed by the MST therapist, based on the assessment, youth and family strengths, referral behaviors, and the goals of the youth and family. Goals of the youth, family, and other key participants in treatment (i.e., probation officer) are documented in the Case Summary as "Desired Outcomes of Key Participants," and these inform the "Overarching Goals" of treatment as documented in the Case Summary.

C Overarching goals are established at the beginning of treatment, while specific objectives are updated each week and closely monitored in the Weekly Case Summaries. In each Weekly Case Summary, the MST therapist reviews the Overarching Goals and:

1. Develops Intermediary Goals that are specific, measurable action-oriented, realistic, and time-limited objectives
2. Outlines intervention steps that will be taken to accomplish each Intermediary Goal
3. Reviews previous Intermediary Goals
4. Documents advances in treatment, to indicate progress being made, and ongoing assessment of barriers, which leads to development of new intermediary goals

D Cultural values and concerns shall be reflected in the MST therapist's assessment of the youth and family and incorporated into interventions, as appropriate. Weekly clinical supervision shall include responsiveness to problems related to racism or discrimination.

E The treatment objectives must demonstrate that MST focuses on community integration by striving to reduce out-of-home placements, improve school attendance and academic success and build natural supports for the family

VII Provider qualifications and responsibilities are met.

A Agencies must be licensed to provide MST services by MST Services, Inc. or any of its approved subsidiaries. An MST agency must be a BH/substance use provider organization, which is a legally recognized entity in the United States and is qualified to do business in Louisiana and meets the standards established by the Bureau of Health Services Financing (BHSF) or its designee. MST agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers.

B The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, certification by MST Services, Inc., staff criminal background checks, tuberculosis (TB) testing, drug testing and required training for staff employed or contracted with the agency. MST-only agencies are not required to be accredited due to the extensive nature of consultation by MST Services, Inc. These agencies must maintain good standing with MST Services, Inc., ensure fidelity to the MST model and maintain licensure through the Louisiana Department of Health (LDH). (NOTE): Agencies providing non-Evidence Based Practice (EBP) rehabilitation and/or addiction services in addition to MST must be accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), or The Joint Commission (TJC).

C MST agencies must adhere to all requirements established in the Provider Responsibilities section located in the LDH Behavioral Health Manual- Outpatient Services: Rehabilitation Services chapter of this manual with the following exceptions

1. Behavioral Health Service Providers (BHSPs) exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide medication management. Such BHSPs shall develop policies and procedures to ensure:
   a Screening of clients for medication management needs.
   b Referral to appropriate community providers for medication management including assistance to the client/family to secure services
   c Collaboration with the client's medication management provider as needed for coordination of the client's care.

2. BHSPs exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a Medical Director. Such BHSPs shall have a Clinical Director in accordance with core staffing requirements as detailed in the LDH Behavioral health Provider Manual under Provider Responsibilities in Section - Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

D MST Therapist- Therapists are master's-level mental health professionals with graduate degrees in a clinical field, a background in family, youth and community service and a minimum of two years of experience is preferred. Highly skilled bachelor's-level professionals may be selected, with certain hiring conditions. These conditions include:

1. Education in a human services field
2. A minimum of three years' experience working with family and/or children/youth services
3. The provider has actively recruited for master's-level therapists but has not found any acceptable candidates or the bachelor's-level applicant is clearly better qualified than the master's-level applicants
4. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population (children/adolescents and their families). Therapists are responsible for providing direct service to a caseload of four to six families. The expectation is that the usage of bachelor's level staff will not exceed one bachelor's-level staff person for every two master's-level staff persons per team

E MST provides LMHP oversight over treatment planning through MST supervision and consultation, which includes weekly review of treatment planning between the MST clinician, MST supervisor, and MST consultant. Supervisor and consultant feedback will be integrated into the Weekly Case Summaries and will be implemented into the upcoming week's intervention plan.

Additional Information

On average, a youth receives MST for three to five months, but typically, no longer than five months. The therapist meets with the youth or family at least weekly but often multiple times per week, depending on need. The MST approach views individuals as being surrounded by a natural network of interconnected systems that encompass individual, family, and extra-familial (peer, school and neighborhood) factors. The MST approach believes that it is often necessary to intervene in a number of these systems to achieve positive results. All interventions implemented during treatment come from evidenced-based treatment approaches. Through a combination of direct service contacts and collateral contacts, significant improvement in family functioning occurs, thereby reducing the need for continued professional services. MST is based on the philosophy that the most effective and ethical way to help youth is by helping their families. MST views caregivers as valuable resources, even when they have serious and multiple needs of their own. One goal of MST is to empower caregivers to effectively parent their children. MST treatment reaches across all of the youth's life domains and is highly individualized around each case.

Treatment principles- These nine principles guide treatment and the development of interventions to address referral behaviors. The treatment theory draws from social-ecological and family systems theories of behavior. Staff supervision and consultation are focused on facilitating use of the MST model. A variety of measures are in place to monitor a program's adherence to the MST model and ensure that fidelity to the model is maintained to the greatest extent possible. Treatment principles include the following:

- The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context
- Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.
- Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members
- Interventions are present-focused and action-oriented, targeting specific and well defined problems
- Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.
- Interventions are developmentally appropriate and fit the developmental needs of the youth
- Interventions are designed to require daily or weekly efforts by family members
- Intervention effectiveness is evaluated continuously from multiple perspectives, with the provider assuming accountability for overcoming barriers to successful outcomes
- Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts

Goals - MST is designed to accomplish the following:

- Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care. Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others
- Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities
- Help caregivers develop effective parenting skills and skills to manage the consumer's mental health needs, improve caregiver decision-making and limit setting
- Improve family relationships
- Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardiness and/or a decrease in job terminations
- Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources will oversee and fund the participation in restorative measures, rather than the MST service provider)
- Reduce likelihood of out-of-home placement and reduce the utilization of out of home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.)
- Develop natural supports for the consumer and family

Coding Implications

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HCPCS Codes	Description
H2033	Multisystemic therapy for juveniles, per 15 minutes

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Policy Created	3/15/23	7/10/23	
Annual Review. References Reviewed and Updated. Changed Policy number from LA.CP.MP.521c.	4/24	7/16/24	
Revisions made to update criteria throughout section as well as to make technical edits throughout section.	10/24	1/27/25	2/27/25

References

LDH Behavioral Health Services provider manual. Appendix E-4: Evidence Based Practices (EBPs) Policy- Multi-Systemic Therapy (MST). Issued 1/12/24. Replaced 2/25/22.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

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