Children & Family Treatment & Support Services (CFTSS)
External Provider Medical Necessity Recommendation Documentation

Youth's Name: ______________________________ Youth's Medicaid Number: _________________

Diagnosis (ICD -10-CM): _______________________________ ICD-10 (F Code): ___________________

Diagnosis Date: ____________________________

I, the undersigned, based on my assessment of need and review of records have determined that the above referenced youth meets medical necessity and would benefit from the provision of the following Children & Family Treatment & Support Service:

Other Licensed Professional (OLP)

The above named youth meets the Medical Necessity for OLP based on at least one of the following criteria:

OLP is necessary to correct or ameliorate conditions that are found through an EPSDT screening.

OLP addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

Licensed Practitioner of the Healing Arts (LPHA):

_________________________________ ___________________________________
Signature & Title Printed Name

_________________________________ ___________________________________
NPI # Date

Children & Family Treatment & Support Services (CFTSS)
External Provider Medical Necessity Recommendation Documentation

Youth's Name: ______________________________ Youth's Medicaid Number: _________________

Diagnosis (ICD -10-CM): _______________________________ ICD-10 (F Code): ___________________

Diagnosis Date: ____________________________

I, the undersigned, based on my assessment of need and review of records have determined that the above referenced youth meets medical necessity and would benefit from the provision of the following Children & Family Treatment & Support Service:

Community Psychiatric Supports & Treatment (CPST):

The above named youth meets the Medical Necessity for CPST based on **ALL** three of following criteria:

The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the youth is at risk of development of a behavioral health diagnosis **AND**

The youth is expected to achieve skill restoration in one of the following areas:

- Participation in community activities and/or positive peer support networks
- Personal relationships
- Personal safety and/or self-regulation
- Independence/Productivity
- Daily Living Skills
- Symptom Management
- Coping strategies and effective functioning in the home, school, social or work environment **AND**

The youth is likely to benefit from and respond to the services to prevent the onset or the worsening of symptoms.

Licensed Practitioner of the Healing Arts (LPHA):

_________________________________ ___________________________________
Signature & Title Printed Name

_________________________________ ___________________________________
NPI # Date

Children & Family Treatment & Support Services (CFTSS)
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Youth's Name: ______________________________ Youth's Medicaid Number: _________________

Diagnosis (ICD -10-CM): _______________________________ ICD-10 (F Code): ___________________

Diagnosis Date: ____________________________

I, the undersigned, based on my assessment of need and review of records have determined that the above referenced youth meets medical necessity and would benefit from the provision of the following Children & Family Treatment & Support Service:

Psychosocial Rehabilitation (PSR)

The above named youth meets the Medical Necessity for PSR based on **ALL** three of following criteria:

The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM **AND**

The youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms **AND**

The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or support the youth's functional level to facilitate integration of the youth as participant of their community and family.

Licensed Practitioner of the Healing Arts (LPHA):

_________________________________ ___________________________________
Signature & Title Printed Name

_________________________________ ___________________________________
NPI # Date

_________________________________ ___________________________________