United Behavioral Health

Optum Idaho Medicaid Level of Care Guidelines

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INTRODUCTION

The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support recovery, resiliency, and well-being.

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®[1]. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently, or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

COMMON CRITERIA

Admission Criteria

- The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
    - Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.
    - The member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning described in Clinical Best Practices.
      AND
- The member's condition can be safely, effectively, and efficiently assessed and/or treated in the proposed level of care. Assessment and/or treatment of the member's condition require the intensity and scope of services provided in the proposed level of care.
  AND
- Co-occurring behavioral health and medical conditions can be safely managed in the proposed level of care.
  AND
- Services are medically necessary.
    - For adults, services are medically necessary if:
        - The service is reasonably calculated to prevent, diagnose, or treat conditions that endanger life, cause pain or cause functionally significant deformity or malfunction;
        - There is no other equally effective course of treatment available or suitable for the member which is more conservative or substantially less costly;
        - Medical services must be of a quality that meets professionally- recognized standards of health care and must be substantiated by records including

[1] Optum is a brand used by United Behavioral Health and its affiliates.

evidence of such medical necessity and quality. Those records must be made available upon request.

- For children and adolescents, services are medically necessary if:
  - The service is necessary to correct or ameliorate defects or mental health conditions, and are not covered for cosmetic, convenience, or comfort reasons;
  - The service is required as defined in Section 1905r of the Social Security Act5;
  - The service is safe and effective;
  - There is no other equally effective course of treatment available or suitable for the member which is more conservative or substantially less costly;
  - The service is substantiated by records including evidence of such medical necessity and quality as documented by the attending provider. Those records must be made available upon request.

  AND
- In addition to the above, adult and child/adolescent services must also meet acceptable national standards of medical practice.
  AND

- For all levels of care, services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of funcitioning.
  - It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patient. For many other psychiatric patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
  - In addition to the above, for outpatient services, some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, coverage depends on whether the criteria discussed above are met; for example, that stability can be maintained without further treatment or with less intensive treatment.

Continuing Stay Criteria

- The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active", service(s) must be as follows:
  - Supervised and evaluated by the admitting provider;
  - Provided under an individualized treatment plan consistent with Common Clinical Best Practices;
  - Reasonably expected to improve the member's presenting problems.

  AND
- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.
  AND
- Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.
  AND
- The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated and feasible.

Discharge Criteria

- The continued stay criteria are no longer met. Examples include:
  - The member's condition no longer requires care.

- The member's condition has changed to the extent that the condition now meets admission criteria for another level of care.
- Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
- The member requires medical/surgical treatment.
- After an initial assessment the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

COMMON CLINICAL BEST PRACTICES

Introduction

In assessing whether the criteria set forth in these guidelines is satisfied, staff should consider the clinical information collected from the provider following evaluation and treatment planning described in Common Clinical Best Practices. Staff should update the clinical information through continued consultation with the provider at appropriate intervals as the treatment progresses, including information about new or different symptoms or conditions that may emerge in the course of treatment.

Evaluation & Treatment Planning

- The initial evaluation:
  - Gathers information about the presenting issues from the member's perspective, and includes the member's understanding of the factors that lead to requesting services;
  - Focuses on the member's specific needs;
  - Identifies the member's goals and expectations;
  - Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- The provider collects information form the member and other sources, and completes an initial evaluation of the following:
  - The member's chief complaint;
  - The history of the presenting illness;
  - The factors leading to the request for service;
  - The member's mental status;
  - The member's current level of functioning;
  - Urgent needs, including those related to the risk of harm to self, others, and/or property;
  - The member's use of alcohol, tobacco, or drugs;
  - Co-occurring behavioral health and physical conditions;
  - The member's history of behavioral health services;
  - The member's history of trauma;
  - The member's medical history and current physical health status;
  - The member's developmental history;
  - Pertinent current and historical life information;
  - The member's strengths;
  - Barriers to care;
  - The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
  - The member's broader recovery, resiliency, and wellbeing goals.
- The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
- The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to develop a treatment plan. The treatment plan addresses the following:
  - The short- and long-term goals of treatment;
  - The type, amount, frequency, and duration of treatment;
  - The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed, and related to the factors leading to admission;
  - How the member's family and other natural resources will participate in treatment when clinically indicated;
  - How treatment will be coordinated with other provider(s), as well as with agencies or programs with which the member is involved.

- As needed, the treatment plan also includes interventions that enhance the member's motivation, promote informed decisions, and support the member's recovery, resiliency, and wellbeing. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
- Treatment focuses on the member's condition including the factors precipitating admission to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
- The treatment plan and level of care are reassessed when the member's condition improves, worsens, or does not respond to treatment.
    - When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
    - When the member's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member's condition should be treated in another level of care.
- In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

Discharge Planning

- The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
- The provider and, whenever possible, the member updates the initial discharge plan during the admission, ensuring that:
    - An appropriate discharge plan is in place prior to discharge;
    - The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
    - The member agrees with the discharge plan.
- For members continuing treatment:
    - The discharge plan includes the following:
        - The discharge date;
        - The post-discharge level of care, and the recommended forms and frequency of treatment;
        - The name(s) of the provider(s) who will deliver treatment;
        - The date of the first appointment, including the date of the first medication management visit;
        - The name, dose, and frequency of each medication, with a prescription sufficient to last until the first medication management visit;
        - An appointment for necessary lab tests;
        - Resources to assist the member with overcoming barriers to care, such as lack of transportation or child care;
        - Recommended self-help and community support services;
        - Information about what the member should do in the event of a crisis prior to the first appointment.
- For members not continuing treatment:
    - The discharge plan includes the following:
        - The discharge date;
        - Recommended self-help and community support services;
        - Information about what the member should do in the event of a crisis or to resume services.
    - The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

BEHAVIORAL HEALTH: OUTPATIENT

OUTPATIENT services are in person, non-electronic services (except when provided via both audio and video using a secure two-way real time interactive telemental health system by a doctoral level or masters level provider who is an independently licensed clinician) and used to treat mental health conditions and substance use disorders.

Services include comprehensive diagnostic assessment, individualized treatment planning, psychotherapy services (i.e. individual, family and/or group, including individual psychotherapy completed in the member's home) and pharmacological management. Other services are rendered in an outpatient setting and are addressed in separate level of care guideline documents.

Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting 60 minutes or longer.

Optum Idaho and the provider network use, "*The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition*" to guide service delivery, level of care placement for Substance Use Disorder (SUD) Services.

Outpatient Admission Criteria

- See Common Criteria
  AND
- The member's presenting signs, symptoms and environmental factors have not been evaluated; an initial evaluation is needed in order to complete a comprehensive diagnostic assessment.
  OR
- The member's presenting signs, symptoms and environmental factors indicate a severity of illness which can be adequately and safely treated with outpatient services.
  AND
- *Comprehensive Diagnostic Assessment***.** At the start of services, the provider shall conduct a comprehensive diagnostic assessment which includes a current mental status examination, as well as a description of the member's readiness and motivation to engage in treatment, participate in the development of the treatment plan and adhere to the treatment plan. The assessment will lead to a DSM diagnosis (or ICD equivalent) with recommendations for level of care, intensity and expected duration of treatment services.
  - In the event the agency makes a determination that it cannot serve the member, the agency must make appropriate referrals to other agencies to meet the member's identified needs.
- *Functional Assessment.* Also at the start of services, the provider shall conduct or update a previous functional assessment which identifies the member's strengths and needs and will be used as part of the clinical record to create a treatment plan with the member and/or their guardian.
- Idaho Department of Health and Welfare has selected the CANS as Idaho's functional assessment tool for children under the age of 18 receiving Medicaid Benefits and will become the only recognized reimbursed tool in the future. This is the tool that will be used to develop treatment plans.

Extended outpatient sessions may be covered in the following circumstances, as indicated by the member's condition and specific treatment needs:

- The member has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder, Obsessive Compulsive Disorder, or Specific Phobia, and is being treated with Prolonged Exposure Therapy.
- The member is being treated with Eye Movement Desensitization and Reprocessing (EMDR) or Traumatic Incident Reduction (TIR) for Posttraumatic Stress Disorder.
- Borderline Personality Disorder is a covered condition, and the member is being treated with Dialectical Behavior Therapy (DBT).

Telemental health service may be covered when:

- The Outpatient Admission Criteria are met.

- A secure two-way real time interactive telemental health system is available to facilitate interaction between the member and the provider using both audio and video.

Providers must be licensed in the state in which the member is located at the time of service. Providers may be physically located outside of Idaho when seeing Idaho members, as long as they are licensed in Idaho.

Services must be delivered in a manner consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security regulations and standards, as outlined in Optum's Telehealth Checklist Protocol and attested to by network provider prior to commencing telemental health services.

The following are **not** considered telemental health because they don't utilize a secure two-way real time interactive telemental health system:

- Phone based services including phone counseling, email, texting, voicemail, or facsimile
- Remote monitoring devices, such as devices which measure respiration rate, body temperature, galvanic skin response, etc.
- Internet-based services including internet-based phone calls

As with any service, however, we depend on our clinicians to determine if telemental health is the appropriate modality for the patient at the time of service. If a patient presents and requires services or an evaluation that is most appropriately conducted in person, we rely on our clinicians to make that determination and to work with the patient and with Optum to coordinate the most appropriate care for the patient.

Neither delivery of group or family psychotherapy to members at different locations via telemental health nor group psychotherapy in general via telemental health is covered by Optum Idaho. However, family psychotherapy is covered if the family is in one location and all other telemental health criteria above are met.

Asynchronous store and forward technologies (including the transmission of a member's clinical record, lab results, or other clinical information from an originating site to the provider at a distant site) is **not** part of the standard of care for telemental health.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- *Treatment Plan.* At the start of services, the provider with the member/member's representative – shall complete a comprehensive diagnostic assessment including a functional assessment of the member's strengths and needs and will develop an individualized treatment plan within 10 days. This plan will include, at a minimum, the following:
    - A statement of the overall goal of treatment as identified by the member/member's representative and concrete, measurable treatment objectives to be achieved by the member, including timeframes for completion. The overall treatment goal and objectives must be individualized and must reflect the choices and preferences of the member/member's representative, and be coordinated with the member's person centered plan, or Wraparound plan if one exists. The overall treatment goal and objectives must address the member's strengths and needs identified by the member/member's representative through the intake and assessment process. The task must be specified to the type of modality used and must specify the frequency and anticipated duration of therapeutic services.
        - The frequency and duration of outpatient visits should allow for safe and timely achievement of the overall goal of treatment, and should support the member's recovery/resiliency. The frequency and duration of outpatient visits should be determined by factors such as the member's

strengths and needs as identified through a functional assessment tool, objectives of treatment, the member's/member's representative's preferences, evidence- based guidance, and the degree of intensity needed to monitor and address imminent risk.

- Providers should ensure documentation of who participated in the development of the individualized treatment plan.
  - Signatures. The member's independently licensed clinician must complete a treatment plan prior to the provision of a behavioral health service. The treatment plan must be signed and dated and placed in the member's record within 30 calendar days of the initiation of treatment. This includes the member/member's representative signature on the document indicating his/her agreement with service needs identified and his/her participation in its development.
  - If these signatures indicating participation in the development of the treatment plan are not obtained, the agency must document in the member's record the reason the signatures were not obtained, including the reason for the member/member's representative's refusal to sign. A copy of the treatment plan must be given to the member/member's representative.
  - Other individuals who participated in the development of the treatment plan must also sign the plan.
  - The author of the treatment plan must include in their signature the author's title and credentials.
- The treatment plan must be created in direct response to the findings of the assessment process, and identify the member's documented and assessed functional needs and deficits.
- The treatment plan must include a prioritized list of issues for which treatment is being sought that are related to the member's assessed needs; include clear, reasonable measurable and objective treatment goals; and the type, frequency, and duration of treatment estimated to achieve all goals based on the ability of the member to effectively utilize services.
- The treatment plan should address how services will be coordinated with the member/family to meet their goals, preferences and needs, and also coordinated with those services delivered by other providers and agencies - including the member's primary care physician, and CFT Interdisciplinary Team, if applicable.
- Treatment plans should address needed linkages with all other services, supports and community resources as indicated necessary by the member/family
- The treatment plan should be developed in collaboration with the member/family and identify the level of participation and involvement of parents or guardians for youth/adolescents receiving care.
- The treatment plan should address how the member/ family prefer other family members or other social supports to be included and participate in treatment when clinically indicated.
- The treatment plan for home based psychotherapy should include why home based therapy is recommended and include documentation of the estimated length of stay for home based psychotherapy.
- The provider must document evidence that the member's primary care physician has conducted a history and physical examination within the last twelve (12) months and annually thereafter. The provider must refer any member who has not had a history and physical examination to the primary care provider.
- Discharge criteria and aftercare plans must be developed in collaboration with the member/family and included on the treatment plan and reviewed as part of any treatment plan review

- **90 day Review and Update of the Treatment Plan**. The provider along with the member/member's representative shall conduct intermittent treatment plan reviews frequently enough to reflect changes in the member's condition, need and preferences, and the period of time between reviews shall not exceed ninety (90) calendar days. This

process will include a functional assessment update.
    - During the reviews, agency staff providing the services, the member/member's representative, and any other members of the interdisciplinary team as identified by the member/member's representative must review the progress the member has made on objectives and identify goals and objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the member/member's representative and recommended by the member's Interdisciplinary team, if applicable.
    - When services are provided by paraprofessionals the treatment plan is completed as a team with a qualified licensed clinician overseeing the treatment being provided. This ensures that treatment planning aligns with all of the therapeutic interventions also underway.

ADULT SERVICES: MENTAL HEALTH - ADULT PARTIAL CARE/SKILLS TRAINING AND DEVELOPMENT (PARTIAL CARE)

ADULT PARTIAL CARE/SKILLS TRAINING AND DEVELOPMENT (PARTIAL CARE) is treatment for adult members with Serious and Persistent Mental Illness (SPMI) whose functioning is sufficiently disrupted to the extent that it interferes with their productive involvement in daily living.
Partial Care is a structured ambulatory program of therapeutic interventions offering less than 24-hour daily group-based care delivered by licensed, qualified professional. These interventions assist members with stabilizing their behavior and conduct, and preventing relapse or hospitalization through the application of principles of behavior modification for behavior change and structured goal-oriented group socialization for skill acquisition.

Partial Care services vary in intensity, frequency, and duration in order to support members in managing functional difficulties, or to otherwise realize recovery goals.

Admission Criteria

- See Common Criteria
  AND
- The member has significant difficulty gaining and utilizing skills necessary to function adaptively in home and community settings, and is at risk of an imminent out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the member's ability to maintain his/her current level of functioning. Necessary skills are related to at least two (2) of the following areas on either a continuous or an intermittent, at least once per year, basis:
    - Vocational/educational;
    - Financial;
    - Social relationships/support;
    - Family;
    - Basic living skills;
    - Housing;
    - Community/legal; or
    - Health/medical.

  AND
- Within ten (10) calendar days of accessing services, the provider shall conduct and document the findings of a comprehensive diagnostic assessment. As part of the assessment, the provider shall assist the member/member's representative with defining the following:
    - The member's readiness to participate in group-based Skills Training and Development (Partial Care);
    - Activities needed to improve the member's readiness such as motivational enhancement or learning activities;
    - In the event the agency makes a determination that it cannot serve the member, the agency must make appropriate referrals to other agencies to meet the member's identified needs;
    - The member's overall goal;
    - The member's present level of skills and knowledge relative to the goal, and the skills and knowledge needed to achieve the member's goal; and

- The member's present resources, and the resources needed to achieve the member's goal;
- The evaluation of resources should include whether the member has a primary care physician, and whether the member has had a history and physical examination within the last 12 months.

AND

- Within 10 calendar days of accessing services, the provider shall use the findings of the comprehensive diagnostic assessment to develop a skills training and development plan in conjunction with the member/member's representative and the interdisciplinary team. The plan shall contain the following:
  - Observable, measurable objectives aimed at assisting the member with achieving his/her goal;
  - The specific intervention for each skill/knowledge or resource objective;
  - The list of interventions should also include a provision to refer the member to a primary care physician if the member has not had a history and physical examination within the last 12 months, and to assist the member with receiving an annual examination thereafter;
  - The person responsible for providing the intervention, and the amount, frequency and expected duration of service.
  - The member/member's representative's signature as an attestation that the member/member's representative agrees with and participated in the development of the plan.

Continuing Stay Criteria

- See Common Criteria

AND

- The provider – and whenever possible, the member/member's representative – shall conduct an intermittent review of the skills plan as needed to incorporate progress, different goals, or change in service focus. The plan should be updated frequently enough to reflect changes in the member's condition, needs and preferences, and the period of time between reviews shall not exceed 90 calendar days.
  - In the event that the member has not engaged in services, the provider shall assist the member/member's representative with re-evaluating the member's readiness for Skills Training and Development (Partial Care) as well as the steps the member/member's representative wants to take to engage in services.
  - In the event that the member has not benefitted from services, the provider shall assist the member/member's representative with determining whether the plan should be modified, or whether the member could benefit from other services.
  - The review must include a reassessment of the member's continued need for services.

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices

ADULT SERVICES: SKILLS BUILDING/COMMUNITY BASED REHABILITATION SERVICES

SKILLS BUILDING/COMMUNITY BASED REHABILITATION SERVICES - ADULT focuses on behavioral, social, communication, rehabilitation, and/or basic living skills training which is designed to build a member's competency and confidence while increasing functioning and decreasing mental health and/or behavioral symptoms. Training is specific to goals identified in the individualized treatment plan. Examples of areas that may be addressed include self-care, behavior, social decorum, avoidance of exploitation, anger management, budgeting, development of social support networks, and use of community resources.

Skills Building/Community Based Rehabilitation Services (CBRS) utilizes qualified practitioners (paraprofessional) supervised by independently licensed clinicians abiding by best practices in psychiatric rehabilitation, as endorsed by the Psychiatric Rehabilitation Association (PRA), to help members, in person, to achieve the intended purpose. Skills Building/CBRS vary in intensity,

frequency, and duration in order to support member's ability to manage functional difficulties and to realize recovery and resiliency goals.

The intent of Skills Building/CBRS is to address the member's specific needs and strengths as identified through functional assessment to the point where the member may be safely, efficiently and effectively treated in the least restrictive service level. Skills Building/CBRS addresses specific functional needs and is not intended for general support service.

Admission Criteria

- See Common Criteria
  AND
- If imminent or current risk is identified upon assessment, the presenting concerns should be addressed in the member's treatment plan in order to assure the member's ability to benefit from the outpatient service. When such risks are present then a safety plan must be completed with the member and their family to include: triggers, current coping skills, warning signs, preferred interventions, and advanced directives (when available).
  AND
- Skills Building/CBRS is deemed appropriate to treat Adults recovering from a Severe and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI) when they have been assessed to have at least two (2) significant functional deficits related to the identified SPMI/SMI and, Skills Building/CBRS services are necessary in order for the adult to obtain, apply, and/or when skills require a defined period of reinforcement, of the developmentally age appropriate skills. Skills Building/CBRS addresses an adult's ability to function adaptively in the home and community settings. The following functional areas to be assessed are as follows:
  - Vocational/educational
  - Financial
  - Social relationships/support
  - Family
  - Basic living skills
  - Housing
  - Community/legal
  - Health/medical

  AND
- Prior to the provision of Skills Building/CBRS and prior to the submission of a service request form, the independently licensed treating clinician, along with the Member shall complete or acquire (if existing) a current Comprehensive Diagnostic Assessment and a functional assessment to develop a specific individualized treatment plan for Skills Building/CBRS with the paraprofessional. Documentation of the member's treatment plan must be in the member's provider medical record within 10 days of the first Skills Building/CBRS treatment appointment with that provider.
  AND
- Skills Building/CBRS is driven by a service specific individualized treatment plan based on a Member's specific needs and strengths identified from the comprehensive diagnostic and functional assessments. Treatment planning for this service is developed using the teaming approach between the independently licensed clinician, the paraprofessional. This specific approach to member care involves the integration of each participant's contribution and role in the treatment plan and is approved by the independently licensed clinician and confirmed with their signature and title. The Member/Member's representative should also be actively engaged in the development of the treatment planning for Skills Building/CBRS.
  AND
- The treatment plan shall contain the following:
  - Observable, measurable objectives aimed at assisting the member in achieving his/her goals related to the specific functional need;
  - The specific Evidence Based intervention(s) for each skill/knowledge or resource objective related to the specific functional need;
  - Documentation of or referral to a primary care physician, if the member has not had a history and physical examination within the last twelve (12) months, and to assist the member with receiving an annual examination thereafter;

- The person responsible for providing the intervention, and the amount, frequency and expected duration of service;
- The member/member's representative's signature as an attestation that the member/member's representative agrees with, participated in the development of the individualized treatment plan, and receives a copy of the plan;

AND

- The treatment plan must be signed and dated and placed in the member's record within 30 calendar days of the initiation of treatment. This includes the member/member's representative signature on the document indicating his/her agreement with service needs identified and his/her participation in its development.
  - If these signatures indicating participation in the development of the treatment plan are not obtained, the agency must document in the member's record the reason the signatures were not obtained, including the reason for the member/member's representative's refusal to sign. A copy of the treatment plan must be given to the member/member's representative.
  - Other individuals who participated in the development of the treatment plan must also sign the plan.
  - The author of the treatment plan must include in their signature the author's title and credentials.

Continuing Stay Criteria

- See Common Criteria

  AND
- The individualized treatment plan should be updated frequently enough to reflect changes in the member's condition, functional needs, goals, progress, preferences, and or change in skill related goals. The period of time between reviews shall not exceed ninety (90) calendar days.

  AND
- The annual CDA, functional assessment and related treatment plan should reflect updates of the Member's goals and preferences, condition, needs, progress and change in service goals from the member's individualized treatment plan. These annually updated documents should be documented and placed into the member's treatment record:
  - Treatment plans and treatment plan updates should be incorporated into the member's record within 10 days of the member's update appointment.
  - A Comprehensive Diagnostic Assessment update should be incorporated into the member's clinical record no longer than 10 days from its completion.

  AND
- If the member/member's representative does not participate in plan review the reason for non-participation should be documented.

  AND
- In the event that the member has not engaged in services, the provider shall assist the member/member's representative with re- evaluating the member's readiness for Skills Building/CBRS, as well as the steps the member/member's representative wants to take to engage in services.

  AND
- In the event that the member has not benefitted from services, the provider shall assist the member/member's representative with determining whether the individualized treatment plan should be modified or whether the member could benefit from other services.

  AND
- Continued care requests should describe the identified Skills Building/CBRS interventions and goals; document the member's attendance and adherence to treatment recommendations, and expectations for progress in the targeted skill. This information assesses the member's current updated functional needs.

Discharge Criteria

- See Common Criteria

  AND
- The discharge plan is created upon admission to the service and updated throughout treatment.

  AND

- Identifies the member's progress meeting their rehabilitation goal(s).
  AND
- Identifies the plan for services and supports needed for gaining, utilizing and/or, providing a defined period of reinforcement for, the developmentally appropriate skills necessary to function adaptively in the home and community settings.
  AND
- Includes information on the continuity of the member's medications.

Clinical Best Practices

- See Common Clinical Best Practices
  AND
- Skills Building is not:
  - Provision of transportation, case management, or any other support or treatment service.
  - Daycare or a substitute for supervision.
    Appropriate if functional assessment updates have not been completed and documented.

ADULT PEER SUPPORT

ADULT PEER SUPPORT are recovery support services in which a Certified Peer Support Specialist utilizes his/her training, lived experience and experiential knowledge to mentor, guide and coach the member as he/she works to achieve self-identified recovery and resiliency goals. These services are designed to promote empowerment, foster self-determination and choice, and inspire hope as the member progresses through the recovery process.
Peer support services are typically delivered to a person with a serious mental illness or co-occurring mental health and substance use disorder who is actively involved in their own recovery process. This specialized support is intended to complement an array of therapeutic services and may be offered before, during, or after mental health treatment has begun to facilitate long-term recovery in the community.

The relationship between the Peer Support Specialist and member receiving services is highly supportive, rather than directive. The duration of the relationship between the two depends on a number of factors such as how much recovery time the member has, how much other support the member is receiving, or how quickly the member's most pressing problems can be addressed. Components of Peer Support Services may include:

- Assistance with setting recovery goals, developing a recovery action plan, a relapse plan, solving problems and addressing barriers related to recovery;
- Encouraging self-determination, hope, insight, and the development of new skills;
- Connecting members with professional and non-professional recovery resources in the community and helping members navigate the service system in accessing resources independently;
- Facilitating activation so that the member may effectively manage his/her own mental illness or co-occurring conditions by empowering the member to engage in their own treatment, healthcare and recovery;
- Helping the member decrease isolation and build a community supportive of the member establishing and maintaining recovery.

Admission Criteria

- See Common Criteria
  AND
- The member has chosen to participate in Peer Support Services;
  AND
- The member is eligible for benefits and Peer Support Services are covered under the benefit plan;
  AND
- The member is 18 years of age or older;
  AND
- The member is not at imminent risk of serious harm to self or others;

AND

- Services are:
  - Within the scope of the Peer Support Specialist's training;
  - Consistent with best practice evidence for Peer Support Services;
  - Appropriate for the member's behavioral health condition;
  - Delivered as a face-to-face service.

AND

- The member requires assistance accessing services or achieving broader recovery and resiliency goals. Examples include:
  - The member has significant difficulty accessing or utilizing ambulatory behavioral health or medical care and the member requires assistance in accessing professional and non-professional resources and services such as:
  - The member relies primarily on using emergency room services.
  - The member has had recurrent inpatient admissions in the last year.

AND

- The member identifies the need to develop a greater capacity to function independently such as:
  - Management of community living skills (employment, education child care, stable housing, transportation, and other service needs);
  - Management of finances;
  - Management physical well-being (hygiene, nutrition);
  - Managing mental health symptoms
  - Management of home environment (meal preparation, home maintenance).

AND

- The member wishes to become engaged in his/her own care and activate his/her own recovery with the development of skills to include:
  - Self-identifying recovery/resiliency goals;
  - Working toward achieving self-identified recovery goals;
  - Successful navigation of the health system;
  - Communication with professional and non-professional resources in the community (e.g., practicing and preparing for communication with doctors, apartment managers; utility companies);
  - Problem solving skills to more effectively manage self- identified stressors and crises;
- Learning to use activation or engagement tools and activities that support wellness (e.g., personal wellness plan, wellness tracking, and support groups to manage the member's behavioral health condition).

AND/OR

- In addition to the above, the member may also meet one or more of the following:
  - The member has sought or plans to seek mental health services from a hospital emergency room and it is unlikely that the member will meet criteria for inpatient admission;
  - The member has significant difficulty maintaining employment or meeting educational goals;
  - The member lives in an unsafe environment or impermanent housing (e.g., homelessness, frequent changes in residence);
  - The member is participating in Community Transitional Support Services and is transitioning from inpatient behavioral health services into the community with expected or demonstrated difficulty successfully completing the transition into the community with the following considerations:
    - Difficulty is based the member's history, or there is evidence of a prior successful transition with the addition of Peer Support Services.
    - The Peer Support Specialist collaborates with a licensed clinician to support the transition.
    - This service is requested by an Optum Idaho Discharge Coordinator, Intensive Care Manager, and/or Regional Care Manager.
- The duration of Community Transitional Support Services is 30 days from date of discharge from inpatient services.

Continuing Stay Criteria

- See Common Criteria
  AND
- For continued service criteria, all of the following criteria must be met:
  - The initial service criteria are still met, recovery services are being delivered and the services are:
    - Provided and documented by the Peer Support Specialist under an individualized recovery plan that is focused on addressing the reasons Peer Support Services are being provided;
    - Provided to the member with a reasonable expectation that the member will to continue to benefit from services within a reasonable period of time.
    - The factors leading to Peer Support Services have been identified and are integrated into the recovery plan and discharge plan.
    - Services are adequately addressing the member's recovery and resiliency needs.

Discharge Criteria

- See Common Criteria
  AND
- The initial and continued stay criteria are no longer met as evidenced by one of the following:
  - The member has not been able to actively participate in Peer Support Services despite a reasonable attempt to engage and motivate the member;
  - The member requests discontinuation of Peer Support Services and the member and Peer Support Specialist have discussed the reasons and impact of discontinuing services;
  - The Peer Support Specialist, member's licensed clinician, and member agree the member has achieved his or her self-identified goals;
  - There is evidence that the member has not responded to or is not likely to respond to Peer Support Services; or the member has not benefited from services as expected in a reasonable period of time.
- When services begin, the Peer Support Specialist and the member develop an initial discharge plan and estimate the length of services.
- During the initiation of services, the Peer Support Specialist and the member update the initial discharge plan based on the member's response to services ensuring that:
  - An appropriate discharge plan is in place prior to discharge;
  - The member agrees with the discharge plan;
- The discharge plan includes:
  - The date services will end;
  - Recommended self-help and community support services;
  - Information about what the member should do to in the event of a crisis.
  - How the discharge plan will be communicated to the member's providers.
- Ongoing discussion should occur between the Peer Support Specialist and the member regarding the member's continued need for services.
- The Peer Support Specialist shares the discharge plan with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge and to trigger outreach and assistance to the member.
- If the member has requested discontinuation of Peer Support Services, a discussion as to the reasons why should occur.
- The Peer Support Specialist should provide the member with information as to how to reactivate or access Peer Support Services in the future if the need arises.
- If it has been determined that the member has achieved established goals, the Peer Support Specialist and member should work to determine if:
  - The member feels comfortable using recovery tools, community resources, and support groups and that the member is comfortable and confident using accessing and utilizing these resources.

- The member is using their personal wellness plan or another recovery management tool and if the member understands when an Advanced Directive should be implemented.
- The member, Peer Support Specialist and other clinicians providing care to the member should develop a plan as to how post- discharge services will be coordinated.

Clinical Best Practices

- See Common Clinical Best Practices
  AND
- Upon referral, the Peer Support Specialist will provide the member with information about Peer Support Services, and confirm that the member desires services.
- In the event that the member declines services, the Peer Support Specialist will inform the member about obtaining services should the need arise.
- Collaboration with the member to complete an initial needs assessment should occur and includes:
  - An inventory of the member's self-identified strengths and other resilience factors such as the member's support network;
  - An inquiry as to whether the member has a personal wellness plan, an advance directive, and/or a plan for managing relapse;
  - An inventory of the member's behavioral health, medical and community support services;
  - An inventory of what the member identifies as the barriers and risk factors which have undermined the member's participation in clinical and community support services, or have otherwise prevented the member from achieving his/her broader recovery goals;
  - An inquiry about the member's need or desire to better understand of his/her condition, its treatment, and the role that community support services can play in the member's recovery.
- The process of recovery planning should be an empowering, engaging and member-centered process that allows the member to take ownership of the service plan.
- The Peer Support Specialist in collaboration with the member and any other individuals selected by the member will create an individualized recovery plan that reflects the member's needs and preferences, and describes the member's individualized goals, interventions, timeframes and measurable results.
- Based upon the member's preference, any of the following may be involved in the development and delivery of the recovery plan:
  - The member's family/social supports;
  - Behavioral health providers;
  - The member's medical provider;
  - Agencies and other programs with which the member is involved.
- At a minimum, the Certified Peer Specialist will collaborate with the member to formally review the recovery plan every 3 months. However, revisions to the recovery plan will be made whenever there are significant changes in the member's condition, needs, or preferences.

  The Certified Peer Support Specialist may not act as a legal representative for the member, participate in determining competence, provide legal advice, or deliver services that are within the scope of a behavioral health or medical provider's licensure.

CRISIS SERVICES

A Mental Health Crisis is a potentially life threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or substance use disorder(s). These persons may be considering self-harm or harm to others, disoriented or out of touch with reality or have a compromised ability to function, or are otherwise agitated and unable to self-calm. An immediate response to their circumstances is needed.

Crisis Response Services are available 24/7 and provide telephonic intervention for members experiencing a mental health crisis. Crisis Response provides assessment and crisis stabilization through counseling, support, active listening or other telephonic interventions to alleviate the crisis,

and offer referrals to services and community providers. Crisis Response service providers are at least an independently licensed clinician, an individual with a master's degree in a group agency under Optum's supervisory protocol, or a person with a Bachelor's degree in a human services field who is trained and certified in Nonviolent Crisis Intervention by the Crisis Prevention Institute (CPI).

The goal of Crisis Response is to ensure the safety and emotional stability of the member to avoid further deterioration of his or her mental status.

If a member's mental health crisis cannot be resolved telephonically and a higher level of intervention is indicated, then the member will be referred to Crisis Intervention Services. In the event of imminent risk of danger to self or others, or if no Crisis Intervention provider is available for immediate intervention, then Emergency Services will be engaged. In the following 24 hours after a mental health crisis, it is best practice for providers to follow up telephonically with the member/member's family to assess member stability and crisis follow-up needs.

Crisis Intervention Services are available 24/7 and provide face-to-face intervention for members experiencing a mental health crisis. Crisis Intervention is provided in the location where the crisis is occurring. Crisis Intervention addresses the immediate safety and well-being of the member, family, and community. Crisis Intervention assesses, intervenes, and coordinates with the member's current behavioral health provider and/or provides referrals to behavioral health and/or emergency services. Additionally, in the following 24 hours after a mental health crisis, crisis service providers will follow up telephonically with the member/member's family to assess member stability and crisis follow-up needs.

Crisis Intervention service providers are at least an independently licensed clinician, an individual with a master's degree in a group agency under Optum's supervisory protocol, or a person with a Bachelor's degree in a human services field who is trained and certified in Nonviolent Crisis Intervention by the Crisis Prevention Institute (CPI).

Admission Criteria

- See *Common Criteria* and *Best Practices for All Levels of Care*
  AND
- The member has self-identified that he/she is experiencing a mental health crisis.
  OR
- The member's family, informal and formal supports have identified that the member is experiencing a mental health crisis.
  OR
  The member needs an immediate risk assessment, mental status exam, substance use screening and evaluation, to determine the member's urgent needs.

Continued Service Criteria

- See Common Continued Stay Criteria for all Levels of Care
  AND
- Crisis services are intended to stabilize the member during a mental health crisis. Crisis service providers practice only within their scope of practice and make referrals as appropriate based on the acuity of the crisis. Crisis services are not supervision of a member after the member is transferred to the appropriate level of care.
  AND
- Based on the risk assessment a determination is made regarding the need for further evaluation or referral to appropriate level of care.

Discharge Criteria

- See Common Discharge Criteria for all Levels of Care
  AND
- The Crisis Service provider and member have created and/or updated the crisis/safety plan.
  AND
- The member has been stabilized to his/her previous level of functioning and/or the member can be safely and effectively treated in an appropriate level of care.

Clinical Best Practices

- See Common Best Practice for all Levels of Care.

FAMILY PSYCHOEDUCATION

Family Psychoeducation (FPE) is an approach for partnering with Members and families to treat serious mental illnesses and/or serious emotional disturbance. "Family" includes anyone that the Member identifies as being supportive in their recovery process. Family psychoeducation is not family therapy. Family Psychoeducation focuses on the behavioral health condition as the focus of instruction, not the family. In family therapy, the family itself is the focus of treatment. While psychoeducation is a typical component of psychotherapy, it is also an effective service when provided as a targeted service to a single family or group of families.

Family Psychoeducation is based on a core set of practice principles as outlined by Substance Abuse and Mental Health Services Administration (SAMHSA). These principles form the foundation of the evidence-based practice and guide practitioners in delivering effective Family Psychoeducation services. Family Psychoeducation is not a short term intervention but rather a series of pre-established curriculum based meetings. Family Psychoeducation gives Members and families information about mental illnesses, helps them build social supports, and enhances problem-solving, communication, and coping skills.

Family Psychoeducation can be provided in a multifamily group or single family format. For multifamily group, services are provided to a group of 2-5 families and members; or single family psychoeducation; services are provided to an individual family and member. Services provided should be identified on the member's plan of care, and driven by the Member's needs and strengths identified from a Comprehensive Diagnostic Assessment, functional assessment and Member/Family goals.

Single Family Psychoeducation requires an independently licensed clinician or an individual with a master's degree who is able to provide psychotherapy in a group agency under Optum's supervisory protocol. However, Providers working with a single family having many members or complex issues may benefit from a second facilitator. Multifamily group psychoeducation (2-5 families) warrants two facilitators, at least one being an independently licensed clinician or an individual with a master's degree who is able to provide psychotherapy in a group agency under Optum's supervisory protocol. The second may be a minimum of a bachelor's level paraprofessional operating in a group agency under Optum's supervisory protocol.

Family Psychoeducation supports the Member/family/caregivers in understanding aspects such as:

- The Member's symptoms of the behavioral health condition and nature of their specific illness
- The impact symptoms have on the Member's development and functioning across environments
- The components of treatment that are known to be effective for the member's specific condition
- The concept of rehabilitation through Skill development
- Other important elements of treatment (example: Medication and Medication Compliance)

Admission Criteria

- See *Common Criteria*
  AND
- Family Psychoeducation is driven by Member's needs and strengths identified from the CDA and functional assessments and the Member/Families/Caregivers goals.
  AND
- Services are strength-based, outcome-focused, culturally competent and individualized.
  AND
- Family Psychoeducation services are provided in the community as structured meetings. The Family Psychoeducation program includes joining sessions, an educational workshop, and ongoing Family Psychoeducation sessions that typically occur every two weeks. These sessions are components of the evidence based protocol as defined in the SAMHSA Evidence-Based Practice KIT for Family Psychoeducation.
  AND

- Services follow an empirically tested format and focus on solving problems that interfere with treatment, illness and symptom management, and coping skills.

Documentation Requirements:

- See Common Criteria
  AND
- Providers should take care to accurately document episodes of Family Psychoeducation. Documentation should include the specific evidence-based curriculum utilized; the reason education was necessary, specific items discussed, and any action items identified.
  AND
- Progress notes on each member to include:
  - Family Psychoeducation type: (Single Family or Multifamily Group, family with or without Member present)
  - Date of service
  - Start and stop times
  - Title and subject matter of evidence-based curriculum
  - Number of participants
  - Role of participants
  - Participants responses or reactions to the subject matter
  - Potential impact on eligible member
  - Name(s) and title(s) of Family Psychoeducation facilitators
  - Name and title of supervising independently licensed clinician submitting claims
  - Date documentation was made in the member's record

Continuing Stay Criteria

- The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active", service(s) must be as follows:
  - Supervised and evaluated by the admitting provider;
  - Provided under an individualized treatment plan that is focused on addressing the factors leading to admission, and makes use of clinical best practices;
  - Reasonably expected to improve the member's presenting problems within a reasonable period of time.

  AND
- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.
  AND
- Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.
  AND
- The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated.
  AND
- Lack of progress is being addressed by an appropriate change in the member's treatment plan, and/or an intervention to engage the member in treatment.

Discharge Criteria

- See Common Criteria
  AND
- The continued stay criteria are no longer met. Examples include:
  - The factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.
  - The factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
  - The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.
  - In the event of relocation, the provider will work with the member/member's

parent or legal guardian to gain access to other appropriate services. The provider will maintain contact with the member/member's parent or legal guardian until the member has accessed other services.
    - The member/member's parent or legal guardian requests an end to services despite the provider's recommendation that they continue.
    - If the member/member's parent or legal guardian refuses further services, the provider should explain the risk of discontinuing services, offer a referral to alternative services, and provide the member/member' s parent or legal guardian with instructions for resuming services should the need arise.
    - Services are not clinically appropriate for the member's condition based on generally accepted standards of practice and benchmarks.
    - The member is no longer receiving active treatment, or there is no longer a reasonable expectation that the member's condition will improve further.
    - With the member/member's parent or legal guardian's documented consent, the provider will coordinate discharge from the program with the provider(s) who will deliver services at the next level of care.

CHILD/YOUTH SERVICES: CHILD AND ADOLSCENT NEEDS AND STRENGTHS (CANS) FUNCTIONAL BEHAVIORAL ASSESSMENT

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) FUNCTIONAL BEHAVIORAL ASSESSMENT is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The way the CANS works is that each item suggests different pathways for service planning and measures outcomes.

Admission Criteria

- See Common Criteria
  AND
- The CANS is necessary in order to identify and address strengths and needs in the youth's functioning that are attributed to behavioral health, developmental, and cognitive impairments.
  AND
- The member and their family seeks to obtain treatment for severe emotional disturbance (SED)
- AND
- The CANS will be used to identify the member's strengths and functional needs and is used to develop the treatment recommendations/interventions to support functional improvement and skill development.

Continuing Stay Criteria

- See Common Criteria
  AND
- CANS updates must be completed as necessary based on the youth's needs or at least every 90 days.

Discharge Criteria

- See Common Criteria
  AND
- All treating providers will use the CANS to both design an effective treatment plan and to adjust treatment planning as necessary for demonstrated treatment outcomes.

Clinical Best Practices

- See Common Clinical Best Practices
- Evaluation and Service Planning

- The initial CANS must be completed in conjunction with an initial or updated Comprehensive Diagnostic assessment and the results shall accompany the CANS for all treatment planning.
- The CANS should be administered with youth and family engagement and results must be reviewed with the youth and family.
- The CANS must be updated every 90 days and the updates reflected in the member's treatment planning.
- The CANS may be completed at anytime to update treatment planning required as a result of change in the member's condition.
- The CANS results must be utilized for the initiation of treatment interventions.
- The CANS must be conducted by a qualified licensed clinician, certifed in the CANS.
- The CANs must be completed comprehensively as indicated in the CANS Manual.
- The CANS must identify the member's strengths and needs which should be translated into treatment targets and goals in the member's treatment plan.
- All available clinical information must be integrated in the CANS assessment process, which may include psychiatric findings, psychological testing, other assessments, medical information, etc.
- With appropriate releases of information, it is expected that this assessment will be shared with other professionals involved in the member's assessment and treatment.

CHILD/YOUTH SERVICES: CHILD AND FAMILY TEAM (CFT) INTERDISCIPLINARY TEAM MEETING

CHILD AND FAMILY TEAM (CFT) INTERDISCIPLINARY TEAM MEETING is an in-person or telephonic planning team meeting to develop, monitor, or modify a plan of care which includes either a person centered plan or Wraparound plan facilitated by a Division of Behavioral Health Clinician for a SED child or youth.

Admission Criteria

- See Common Criteria
  AND
- Required to support a member who has a interdisciplinary team meeting for the purpose of developing a behavioral health plan of care
  AND
- The Provider must appropriately document their attendance and contribution at the Coordinated Care Plan Meeting with the appropriate date and beginning/ending times.
  AND
- The following are <u>not</u> considered CFT interdisciplinary activities:
  - Any provider case consultation or treatment planning activities that occur outside of the CFT Interdisciplinary Meeting or outside of the CFT Interdisciplinary.
  - Update Meetings for behavioral health planning
  - Travel time.

Continuing Stay Criteria

- See Common Criteria
  AND
- Providers for eligible members will participate in CFT Interdisciplinary meetings established by the plan facilitator during initial plan development, and/or any Coordinated Care Plan meeting established by the facilitator when an updated Coordinated Care Plan is necessary.
  AND
- Provider documentation should include issues discussed, who was consulted, and the resulting recommendations and actions that will be taken by the provider.
  AND
- Providers who seek reimbursement for attendance at a member's Coordinated Care Plan meeting must be working to complete a specific treatment plan based on Optum Idaho's requirements for treatment planning or have an active treatment plan with the member.

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The team is responsible to review services and progress towards objectives in the youth's Coordinated Care Plan. This allows a provider to attend and participate in the meeting when the provider is actively involved in the development, revision, and implementation of the services needed.
- The CFT Interdisciplinary Team Meeting is scheduled by the assigned Coordinated Care Plan facilitator. During this scheduled meeting, collaboration may occur between two or more of the following: the case manager, treating clinicians, physician and other professionals or paraprofessionals, and family and others as selected by the family to be involved in the youth's care and at the meeting. CFT interdisciplinary collaboration may include network provider attendance or telephonic participation at interdisciplinary planning team meetings (in any setting identified by the interdisciplinary facilitator and family)
- Providers who work with IBHP youth members who have an Optum-approved Person Centered Plan, or Division of Behavioral Health Wraparound plan, must use that member's Coordinated Care Plan and corresponding clinical documentation (e.g., CANS results, Comprehensive Diagnostic Assessment) to identify the member's strengths and functional needs and guide development of the member's overall behavioral health treatment. These clinical documents should be maintained in the member record.
- Specific documentation of attendance at a CFT meeting must include a description of the CFT interdisciplinary collaboration that occurred (date, duration) and also name the professional(s) who were in attendance, along with their credentials, and the resulting recommendations from the meeting. As a provider submitting a claim for attendance; documentation of owned action items that resulted from the meeting and how they will be acted upon are also required.
- Providers will adhere to the YES Principles of Care and Practice Model as defined in the Jeff D Settlement Agreement
- Optum Idaho Provider Manual should be referenced by Network Providers.

CHILD/YOUTH SERVICES: FAMILY SUPPORT SERVICES

FAMILY SUPPORT SERVICES provides assistance to caregivers who are caring for a child diagnosed with a mental health disorder, or a coexisting mental health, developmental and/or substance use disorder by strengthening their role as parents through the provision of teaching and support services, and reducing the likelihood that the family and member will become isolated, disempowered, or disengaged. Examples of these services include:

- Teaching the family members how to develop self-advocacy
- Role modeling behaviors and skills needed for resiliency and coping
- Helping the family utilize their strengths
- Teaching caregivers and members about causes of disorders and about using evidence-based interventions

Family Support Services are provided by a Certified Family Support Partner (CFSP) who is a parent or adult caregiver, and through lived experience and specialized training has acquired an understanding of another parent's situation via the shared emotional and psychological challenges of raising a child with a mental health diagnosis. The CFSP establishes a connection and a trust with the member and family not otherwise attainable through other service relationships (e.g. counseling, psychologist, minister) or someone without the shared experience.

Services take place in the member's community, are focused on the member's family, the role of the member in the family, and guided by the member and family. Services consider the member's rights and cultural needs. The purpose for these services is to help the family feel less isolated, more empowered throughout the recovery process and engaged in the community. Services aim to improve the quality of life and opportunities for recovery in the child's home, school, and community through engagement with the family as well as the member.

Family Support Services are focused on addressing the factors that precipitated access to this service to the point that the member's condition can be safely, efficiently and effectively treated without the support of Family Support Services.

Family Support Services are not provided in lieu of other services and are intended to complement the member's behavioral health treatment and/or other services being provided, and may be delivered while the member is in treatment or in advance of the start of treatment.

Admission Criteria

- See Common Criteria
  AND
- The member is under 18 years of age and resides in the state of Idaho.
  AND
- The member has a DSM diagnosis other than a standalone substance- related disorder or developmental disability diagnosis; although a substance-related disorder or developmental disability disorder may coexist with other DSM diagnoses.
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- The factors that precipitated access to this service indicate that the member's family and member require assistance with accessing treatment and/or community resources. Examples include:
    - The member's family requires information about the member's behavioral health condition, evidence-based treatment, approaches to self-care, or community resources.
    - The member's family could benefit from learning skills related to problem-solving, communication, managing crises or stress, supporting and engaging the child's activation and self-care, or promoting recovery and resiliency.
    - The member's family requires assistance navigating the system of care.

  AND
- The member is receiving behavioral health therapeutic services, or is likely to engage in therapeutic treatment with the provision of Family Support Services.
  AND
- The member and member's family do not demonstrate at least one of the following:
    - Knowledge of wellness tools and their use;
    - The presence of a support system;
    - A sense of purpose;
    - A sense of empowerment;
    - Hope about recovery;
    - The ability of the family to self-advocate;
    - Progressing toward independent living;
    - Engagement with community, school and positive recreational activities.

Continuing Stay Criteria

- See Common Criteria
  AND
- The CFSP is working toward the following outcomes with the family:
    - The ability to identify and use wellness tools;
    - Progress towards age-appropriate, adaptive skills for independent living;
    - Re-engaging with support systems that may have been lost;
    - A sense of purpose;
    - Increased empowerment;
    - Ability for family self-advocacy
    - Increased engagement with supportive services for community, school, and positive recreational activities.

Discharge Criteria

- See Common Criteria
  AND
- The frequency and length of services are determined by the member's mental health team (i.e., clinician, parents/guardians, member, CFSP and evidence-based practices.

Clinical Best Practices

- See Common Clinical Best Practices
  AND
- The provider must be a Certified Family Support Partner per the CFSP standards and the same provider cannot provide both CFSP and clinical services, or other non-CFSP services to the member.
- The CFSP completes an evaluation of the family's needs upon referral.
- For members who are transitioning from Inpatient or Residential Treatment, the CFSP contacts the member's family prior to discharge or within 24 hours of referral.
- As part of the evaluation, the CFSP provides the member's family with information about Family Support Services, and verifies that the member's family wants these services.
- In the event that the member's family declines services, the CFSP provides information about obtaining services should the family's needs change.
- The CFSP, in conjunction with the member's family, develops a service plan within 15 days of the evaluation that addresses the following:
    - The member's recovery and resiliency goals;
    - The member and family's strengths;
    - The member and family's educational needs;
    - The member and family's self-care needs and resources;
    - Problems;
    - Specific and measurable goals for each problem;
    - Interventions that will support the member's family and member in meeting the goals.
- The service plan may be informed by the findings of the member's clinical evaluation.
- The CFSP provides the following services to the member and the family:
    - Advocating for the needs of the family;
    - Teaching family members and the member how to develop self- advocacy and problem-solving skills;
    - Mentoring the member and family to instill a sense of hope;
    - Role modeling behaviors, attitudes and thinking skills needed for resiliency and coping;
    - Helping family members identify and utilize their strengths;
    - Role modeling the facilitation of collaborative relationships;
    - Teaching the member and family about causes of disorders and importance of adhering to treatment; utilizing evidence-based interventions that assist in meeting goals;
    - Assist the family in identifying and connecting to services and community resources;
    - Assist family members in articulating their needs and goals in preparing for meetings as well as service plans;
    - Provide family-based programs such as classes on parent special needs children;
    - Teach caregivers how to document all activities that pertain to the child's appointments, meetings, needs, goals, and strengths, and;
    - Assist in preparing for the child's transition to adulthood.
- The frequency and length of service are periodically re-evaluated depending on the intensity of the CFSP services needed. The higher the intensity and frequency of the services, the more often re-evaluation occurs.
- The service plan must be reviewed at a minimum of every 120 days.

CHILD/YOUTH SERVICES: RESPITE

RESPITE is a short-term or temporary care for a youth with Serious Emotional Disturbance (SED) provided in the least restrictive environment that provides relief for the usual caretaker and that is aimed at de-escalation of stressful situations. Respite may be provided by a credentialed behavioral health agency in the participant's home, another private residence, the credentialed agency or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.

Individual Respite Care is provided by a credentialed agency in the member's home, another family's home, foster family home, and/or at the agency facility or in the community. The duration of individual Respite Care varies and may include an overnight stay in the member's home, as

identified by the Child and Family Team (CFT), but will not exceed a single episode of 72 hours. Individual Respite Services shall be provided at a staff-to-participant ratio of 1:1.

Group respite may be provided at the credentialed agency facility, in the community setting or in the home for families with multiple Medicaid eligible SED children. Group Respite Services shall be provided at a staff-to-participant maximum ratio of 1:4. Group Respite does not allow for an overnight stay. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly.

The following limitations apply to Respite Care:

- Payment cannot be made for room and board. Respite cannot be provided at the same time other Medicaid services are being provided.
- Respite cannot be provided on a continuous, long-term basis as a daily service to enable an unpaid caregiver to work.
- The respite provider must not use restraints on the child, other than physical restraints in the case of an emergency.
- Physical restraints may only be used by staff with documented training in the use of restraints and in an emergency to prevent injury to the child or others, and must be documented in the child's record.
- Only enrolled network providers may provide respite for reimbursement under the Idaho Behavioral Health Plan.
- Individual respite provided in the family's home cannot exceed a single episode of 72 hours
- Individual respite care provided in an agency or community setting cannot exceed a single episode of 10 hours
- Respite services shall not be provided to an individual at the same time as another services that is the same in nature and scope regardless of source, including Federal, State, local, and private entities

The total annual (calendar) limit for Respite (Group and Individual combined) for a member is 300 hours per calendar year.

Admission Criteria

- See Common Criteria
  AND
- The member has completed an assessment by an Independent Assessor
  AND
- The member is eligible per the 1915(i)
  AND
- The need for Respite is documented on the members Person Centered Plan
  AND
- The member is willing to receive Respite and willing to be assessed by a treating professional.
  AND
- The member needs the support of Respite services so that the member can remain in his/her current living situation.
  AND
- The member is actively engaged in outpatient treatment and/or community-based services as defined by the member's Child and Family Team (CFT)
  AND
- Factors identified in the Child and Adolescent Needs Assessment (CANS) that precipitated admission (e.g., the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicates that the member's family or caregiver requires a temporary break from caregiving. Accessibility to child care resources and/or respite is indicated in the CANS as a need. Examples of need reflected In the CANS may include:
  - Prevention of a potential disruption in the child's placement
  - Caregiver strain

  AND
- Other responsibilities temporarily prevent the member's family or caregiver from assisting the member with Activities of Daily Living (ADLs).

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The responsible provider evaluates the member and caregiver's need based on the CANS and Person Centered Plan
- The responsible provider, in conjunction with the Child and Family Team, member and/or member's family or caregiver, develops Person-Centered Plan that includes the following:
    - The goal(s) of Respite Care;
    - Specific, measurable objectives aimed at achieving the goal(s) of Respite Care as defined in the CANS, e.g. scores in particular areas equate to certain needs.
- Clinical documentation signed by the child's parent/guardian incorporates instructions for medication assistance, medical care, special needs and emergencies, and assures that the person centered plan is updated.
- The Person Centered Plan also addresses the need for other services and resources that become apparent during the provision of Respite Care. Respite worker is required to coordinate with the member's primary treating clinician if there is a need for provision of other services or resources that need to be addressed. As needed, the provider assists the member with accessing other services and resources after coordinating care with the primary therapist, and assuring that the member's respite plan is updated.
- The Person Centered Plan is informed by the findings of the initial clinical evaluation.
- Providers of respite must demonstrate the ability to provide respite services according to a plan of care.
- Providers of respite services must meet the qualifications prescribed for the type of services to be rendered and demonstrate the ability to provide the service according to a plan of service. Provider Qualifications are specified in the Optum Idaho Provider Manual.
- The provider ensures that necessary medication, medical equipment, and assistive technology accompany the member when Respite Care is provided at a site other than the member's residence. This must be discussed and communicated with the family/guardian.
- Providers of respite must maintain adequate member and service documentation.
- All respite providers have received and documented instructions in the needs of the child who will be provided the service.
- Providers of respite must always document a member's medication needs (prescribed medication or non-prescribed medication), and have a documented plan for the provision of these needs, as required for the member's continuity of care during the provision of respite.
    - Respite providers will ensure that all medication assistance provided is done with the parent/guardian's written consent and description.
    - Respite providing agencies will develop written medication policies and procedures that outline and detail how the agency will ensure appropriate handling and safeguarding of medication. An agency that chooses to assist participants with medication must also develop specific policies and procedures to ensure this assistance is safe and is delivered by qualified, fully trained staff. Documentation of training must be maintained in the staff personnel file.
    - When a member is responsible for administering his or her own medication without assistance, a written approval stating that the participant is capable of self-administration must be obtained from the participant's primary physician or other practitioner of the healing arts and guardian. The participant's record must also include documentation that a physician or other practitioner of the healing arts, or a licensed nurse has evaluated the participant's ability to self-administer medications.

SKILLS BUILDING/COMMUNITY BASED REHABILITATION SERVICES FOR CHILDREN & YOUTH are services focus on behavioral, social, communication, rehabilitation, and/or basic living skills training which is designed to build a youth's competency and confidence while increasing functioning and decreasing mental health and/or behavioral symptoms. Training is related to goals identified in the individualized treatment plan. Examples of areas that may be addressed include self-care, behavior, social decorum, avoidance of exploitation, anger management, budgeting, development of social support networks, and use of community resources.

Skills Building/Community Based Rehabilitation Services (CBRS) utilizes qualified practitioners supervised by licensed clinicians abiding by best practices in psychiatric rehabilitation, as endorsed by the Psychiatric Rehabilitation Association (PRA), to help members, in person, to achieve the intended purpose. Skills Building/CBRS vary in intensity, frequency, and duration in order to support member's ability to manage functional difficulties and to realize recovery and resiliency goals.

The intent of Skills Building/CBRS is to address the member's specific strengths and needs as identified through functional assessment to the point where the member may be safely, efficiently and effectively treated in the least restrictive service level. Skills Building/CBRS addresses specific functional needs and is not intended for general support service.

These criteria should be used in conjunction with the criteria for admission and continuing service to determine medical necessity for initial and ongoing services.

Admission Criteria

- See Common Criteria
  AND
- If imminent or current risk is identified upon assessment, the presenting concerns should be addressed in the member's treatment plan in order to assure the member's ability to benefit from the outpatient service. When such risks are present then a safety plan must be completed with the member and their family to include: triggers, current coping skills, warning signs, preferred interventions, and advanced directives (when available).
  AND
- Skills Building/CBRS is deemed appropriate to treat Children/Youth recovering from a serious emotional disturbance (SED) when a child/youth diagnosed with a SED has been assessed to have at least 1 significant functional deficit related to the identified SED and Skills Building/CBRS is necessary for the child to obtain, apply and/or, when there is a need for a defined period of reinforcement, of the developmentally age appropriate skills. Skills Building/CBRS addresses a child/youth's ability to function adaptively in the home and community settings. SED is defined in the Youth Empowerment Services terms[i]. The Functional categories to be assessed are as follows:
  - Vocational/education
  - Social relationships/support
  - Family
  - Basic living skills; and/or
  - Community/Legal

  AND
- The treatment plan for Skills Building is to be developed and provided by network providers, both paraprofessional and a qualified licensed clinician, along with the member/family that actively collaborates as a treatment team to develop the member's treatment plan. Treatment team collaboration is described in the Optum Idaho Provider Manual.
  AND
- Prior to the provision of Skills Building/CBRS and prior to the submission of a service request form, the primary clinician, along with the child/youth and family shall complete or acquire (if existing) a current Comprehensive Diagnostic Assessment and a functional assessment to develop a treatment plan for Skills Building/CBRS. The member's providers are required to follow-up and coordinate with the member's treatment team throughout the provision of the service. Documentation of the member's treatment plan must in the member's provider

medical record within 10 days of the first Skills Building/CBRS treatment appointment with that provider.
AND

- The treatment plan shall contain the following:
  - Observable, measurable objectives aimed at assisting the member in achieving his/her goal;
  - The specific Evidence Based intervention(s) for each skill/knowledge or resource objective;
  - Documentation of or referral to a primary care physician, if the member has not had a history and physical examination within the last twelve (12) months, and to assist the member with receiving an annual examination thereafter;
  - The person responsible for providing the intervention, and the amount, frequency and expected duration of service;
  - The member/member's representative's signature as an attestation that the member/member's representative agrees with, participated in the development of the care plan, and receives a copy of the plan;
  - The plan to involve the member's parent or legal guardian in services.

  AND
- If the Member is eligible through the 1915(i) or Medicaid SED program, Skills Building services must be included on the person centered plan and are based on the strengths and needs identified through the functional assessment along with a Comprehensive Diagnostic Assessment, both of which are completed by a qualified licensed clinicians; along with a treatment plan that addresses the member's functional needs.
  AND
- If the Member is not eligible through the Medicaid SED program and/or does not have person centered plan, Skills Building services are based upon the results of a provider specified functional assessment and Comprehensive Diagnostic Assessment, along with a Skills Building/CBRS specific treatment plan both of which are completed by a qualified licensed clinicians; along with a treatment plan that addresses the member's functional needs.
  AND
- For a child whose parent or legal guardian does not participate in the services, the provider must document efforts made to involve the parent or legal guardian and must make appropriate adjustments to the treatment plan to address the parent or legal guardian's lack of involvement.

Continuing Stay Criteria

- See Common Criteria
  AND
- The plan should be updated frequently enough to reflect changes in the member's condition, needs, goals, progress preferences, and change is service goals. The period of time between reviews shall not exceed 90 calendar days.
- For Medicaid SED qualified youth/adolescent members, the 90 day treatment updates are also required in order to incorporate the 90 day CANS functional assessment results,
  OR
- For Non Medicaid SED qualified youth/adolescent members, the 90 day treatment updates are required in order to reflect the provider specified functional assessment results.
  AND
- The annual functional assessment and CDA and related treatment plan should reflect updates of the member/family goals and preferences, condition, needs, progress and change in service goals from the member's plan of care. These annually updated documents should be documented and placed into the member's treatment record:
  - Treatment plans and treatment plan updates should be incorporated into the member's record within 10 days of the member's update appointment.
  - A Comprehensive Diagnostic Assessment update should be incorporated into the member's clinical record no longer than 10 days from its completion.

  AND
- If the member/member's representative does not participate in plan review the reason for non-participation should be documented.
  AND

- In the event that the member has not engaged in services, the provider shall assist the member/member's representative with re- evaluating the member's readiness for Skills Building/CBRS, as well as the steps the member/member's representative wants to take to engage in services.
  AND
- In the event that the member has not benefitted from services, the provider shall assist the member/member's representative with determining whether the care plan should be modified or whether the member could benefit from other services.
  AND
- Continued care requests should describe the identified Skills Building/CBRS interventions and goals; document the member's attendance and adherence to treatment recommendations, and expectations for progress in the targeted skill. This information assesses the member's current updated functional needs.

Discharge Criteria

- See Common Criteria
  AND
- The discharge plan is created upon admission to the service and updated throughout treatment.
  AND
- Identifies the member's progress meeting their rehabilitation goal(s).
  AND
- Identifies the plan for services and supports needed for gaining, utilizing or, a defined period of reinforcement for, the developmentally appropriate skills necessary to function adaptively in the home and community settings.
  AND
- Includes information on the continuity of the member's medications.

Clinical Best Practices

- See Common Clinical Best Practices
  AND
- Skills Building is not:
  - Provision of transportation, respite, case management, or any other support or treatment service.
  - Daycare, childcare or a substitute for parental supervision.
  - Provided without involvement, communication and coordination with the family and/or legal guardian.
    Appropriate if functional assessment updates have not been completed and documented.

BEHAVIORAL HEALTH CASE MANAGEMENT

CASE MANAGEMENT is a collaborative process that assesses, plans, links, coordinates, and monitors options and services that address a member's needs. Case management is provided to members with a behavioral health diagnosis who are unable to navigate or coordinate the service system independently. Case management helps the member learn about, gain and maintain access to services and providers. Case management cannot be provided by the same individual who provides other direct care services to the member.

Admission Criteria

- See Common Criteria
  AND
- The member has a behavioral health diagnosis.
  AND
- The member requires access to behavioral, medical, and/or social services to remain stable in the community.
  AND
- The member is unable to access and/or arrange social services on his/her own without case management assistance.
  AND

- The member's record reflects documentation of an assessment to determine whether the member needs assistance with accessing community-based services

Continuing Stay Criteria

- See Common Criteria
  AND
- The case manager is actively helping the member obtain needed services by linking the member to services, providers and/or programs.
  AND
- The case manager is monitoring and maintaining contact with the member as necessary to ensure the case management service plan is implemented and is adequately addressing the member's needs.
  AND
- Case management documentation must adequately reflect what the member has been able to accomplish with case management.
  AND
- The case management service plan should be updated and include an ongoing assessment of the member's capacity to independently access services.

Discharge Criteria

- See Common Criteria
  AND
- The member is able to access and/or arrange social services on his/her own without case management.

Clinical Best Practices

- See Common Clinical Best Practices
  AND
- The Case manager in conjunction with the member and the member's treatment team develop a case management service plan that includes a description of the following:
  - Strengths
  - Specific and measurable goals for identified needs.
  - Case Management activities that will support the member in meeting their individual goals.
- Non-Covered Services include:
  - Case Management is not covered when it is duplicative of another covered Medicaid service being provided.
  - Case Management is not covered when it involves the direct delivery of medical, educational, social, or other non-Case Management services (e.g., disease education, medical monitoring, or instruction in health self- management, teaching, coaching or training are not covered.)
  - Case Management is not covered for the delivery of services integral to a non-Medicaid program. For example, case management is not covered for member activities related to the following programs:
    - Parole and probation programs,
    - Public guardianship programs,
    - Child welfare/child protective services,
    - Foster care programs, and
    - Special education programs except for Case Management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Act.
  - A Case Manager may not be reimbursed for any transportation of member to and from appointments. Transportation of members is covered by Medicaid and can be arranged by the case manager for the member.

MENTAL HEALTH: INTENSIVE OUTPATIENT SERVICES

INTENSIVE OUTPATIENT SERVICES: MENTAL HEALTH is a structured program that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal

distress and/or significant psychosocial and environmental issues. Intensive Outpatient Programs provide education, treatment, and the opportunity to practice new skills outside the program.

The course of treatment is focused on addressing the member's condition to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.
An Intensive Outpatient Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

Optum Idaho does not support coverage for Intensive Outpatient Program services that are coupled with overnight housing.

Admission Criteria

- See Common Criteria
  AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction a minimum of 9 hours per week for adults and 6 hours per week for children/adolescents. Examples include the following:
  - Assessment requires frequent interaction with the member and observation of the member with others.
  - The treatment plan must be frequently changed, which requires that the provider have face-to-face interactions with the member several times a week.

  OR
- The member requires engagement and support which requires extended interaction between the member and the program. Examples include:
  - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.
  - The member has been unable to access or utilize the member's family or other natural resources on his or her own.

  OR
- The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
  - Maintain their current living situation;
  - Return to work or school.

  OR
- The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of skills include those that help the member:
  - Assistance with developing the skills needed to self-manage medications;
  - Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

  AND
- Coverage is not supported for Overnight Housing Coupled with an Intensive Outpatient Program by Optum Idaho.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
  AND

- The responsible provider and the treatment team complete the initial evaluation commensurate with the member's needs, no later than three (3) treatment days after admission.
- During admission, a psychiatrist is available to consult with the program during and after normal program hours.

TARGETED CARE COORDINATION

Targeted Care Coordination – Children and Adolescents: Targeted Care Coordination (TCC) is the service provided by a targeted care coordinator. The targeted care coordinator is responsible for coordinating and facilitating the Child and Family Team (CFT) interdisciplinary team meetings face to face for the purpose of developing an outcome-focused, strengths-based person-centered service plan that includes both formal and informal services and supports. The targeted care coordinator will be responsible to ensure that services are accessed, coordinated, and delivered in a strengths-based, individualized and relevant manner and that services and supports are guided by family voice and choice. TCC services must reflect the core Principles of Care and be consistent with the Practice Model. The targeted care coordinator will serve as a care navigator for the family and will be responsible for promoting integrated services, with links between child-serving providers, systems and programs. The Targeted Care coordination that occurs is not intended to be duplicative of any other service. Targeted care coordination cannot be provided by the same individual who provides other direct care services to the member. Targeted care coordination occurs through face to face or telephonic contact. Targeted Care Coordination can be delivered as a community-based service or in the outpatient clinic setting.

Admission Criteria

- See Common Criteria
  AND
- A youth member with a serious emotional disturbance (SED)
  AND
- The member's presenting signs, symptoms and environmental factors indicate a severity of illness which can be adequately and safely treated with outpatient services.
  AND
- The member is not receiving duplicative case management services

Continued Service Criteria

- See Common Criteria

Discharge Planning and Criteria

- See Common Criteria

Clinical Best Practices

- See Common Criteria and Best Practices for All Levels of Care
  AND
- Targeted Care Coordination (TCC) must be consistent with the core Principles of Care and the Practice Model of the Idaho Youth Empowerment Services (YES) system of care.
  See:Optum Idaho Provider manual
  AND
- The targeted care coordinator ensures that medically necessary services are accessed, coordinated, and delivered in a strengths-based, individualized, and culturally and linguistically relevant manner, and that services and supports are guided by family voice and choice and the needs of the youth.
  AND
- Through engagement, the TCC will provide support and validation to gain trust to develop and maintain a constructive and collaborative relationship among the youth, family, and involved network providers, community stakeholders, child servicing systems, and other formal and informal supports.
  AND
- The Targeted Care Coordinator (TCC) is responsible for coordinating and facilitating the Child and Family Team (CFT) interdisciplinary team meetings for the purpose of developing an outcome-focused, strengths-based coordinated care plan (e.g. a person-centered service plan) that includes both formal and informal services and supports. The TCC will coordinate and

facilitate the CFT to assess and/or reassess the strengths and needs of youth and their families to determine if changes are needed to update or modify the coordinated care plan.
AND

- The TCC monitors to ensure that outcomes of services and activities are progressing appropriately by evaluating the goals and interventions.
  AND
- The TCC works within the CFT to ensure that plans from other system partners (child welfare, education, juvenile probation, etc.) are integrated comprehensively to coordinate and support success.
  AND
- The TCC documents the recommendations / updates of the CFT on the coordinated care plan and distributes the plan to the team.
  AND
- The targeted care coordinator preforms monitoring and adapting as the practice of evaluating the effectiveness of the person-centered service plan; assessing circumstances and resources; and reworking the person-centered service plan, as needed. The targeted care coordinator conducts referral, linkages, monitoring, and follow up activities, to ensure that the youth and family's needs are met.
  AND
- The targeted care coordinator works within the CFT to develop a crisis/safety plan. This plan is designed to help youth and families avoid and/or deescalate a crisis by addressing safety concerns, predicting potential areas of crisis and identifying ways to minimize a crisis. This plan should be reviewed routinely to make sure it is updated.
  AND
- The targeted care coordinator is responsible for engaging the CFT in developing a transition plan for the youth and family, to promote long-term stability. This transition plan includes the effective use of natural supports and community resources.
  AND
- The targeted care coordinator facilitates the development of a conflict resolution process to resolve disagreements and assist the team with arriving at a mutually agreed upon approach.
  AND
- The targeted care coordinator should have contact with the member and the member's family or guardian at least every 30 days to support the family's involvement in treatment and to further the treatment and discharge planning goals. If the targeted care coordinator cannot reach the member or member's family or guardian they should document attempts made and a plan to re-establish contact.
  AND
- Please see Optum Idaho CFT interdisciplinary team meeting LOCGs.

SUBSTANCE-RELATED DISORDERS: INTENSIVE OUTPATIENT SERVICES

Optum Idaho and the provider network use, "*The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition*" to guide service delivery, level of care placement for Substance Use Disorder (SUD) Services.

TESTING: PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING

PSYCHOLOGICAL TESTING ADMISSION CRITERIA AND CLINICAL BEST PRACTICES

- See above common admission criteria and common clinical best practices for testing.
  AND
- The provider's professional training and licensure include any of the following:
  - A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
  - A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed doctoral-level psychologist, and whose services are billed by the supervising psychologist.
    - The supervising psychologist must have face-to-face contact with the member at intake and during the feedback session.
    - The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.

- A masters-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.
    - The masters-degreed provider has professional expertise in the types of tests/assessments being administered.
    - The masters-degreed provider is conducting test administration, scoring and interpretation in accordance with licensing standards and psychological testing professional and ethical standards.

- Psychological testing related to the treatment of chronic pain may be conducted when:
    - There is a need to further assess mood and personality characteristics which may influence the member's experience or perception of the basis or tolerance of pain, as well as the member's ability to cope with his/her pain;
      OR
    - When the member shows changes in cognitive or intellectual functioning after the long-term use of alcohol, street or prescription drugs, or upon the discontinuation of, or non-response to pain-relieving or psychotropic medications.

- Psychological testing as a component of pre-surgical evaluation may be conducted to rule out behavioral health conditions that could contraindicate surgery, to determine the member's ability to understand the related risks and benefits or surgery, and/or to evaluate the member's ability to participate responsibly in post-surgical recovery behaviors and lifestyle changes.

NEUROPSYCHOLOGICAL TESTING ADMISSION CRITERIA AND CLINICAL BEST PRACTICES

- See above common admission criteria and common clinical best practices for testing.
  AND
- Neuropsychological testing is within the scope of the provider's professional training and licensure when the provider is any of the following:
    - A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
    - A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed doctoral-level psychologist, and whose services are billed by the supervising psychologist.
        - The supervising psychologist must have face-to-face contact with the member at intake and during the feedback session.
        - The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.
    - A credentialed psychiatrist who meets the following requirements:
        - Recognized certification in neurology through the American Board of Psychiatry and Neurology;
        - Accreditation in behavioral neurology and neuropsychiatry through the American Neuropsychiatric Association;
        - State medical licensure specifically allowing for the provision of neuropsychological testing service(s);
        - Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
        - Physician and supervised psychometrician(s) adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.
- Medical application of Neuropsychological testing may be covered under the medical benefit for members with the following conditions when the result of testing will influence clinical decision making (for more information, see www.unitedhealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Neuropsychological Testing Under the Medical Benefit):
    - Attention-deficit/hyperactivity disorder (ADHD) when all of the following are present:
        - Specific neurocognitive behavioral deficits related to ADHD need to be evaluated
          AND

        - Testing has been recommended by a physician and is related or secondary to a known or suspected organic-medical condition resulting from brain injury or disease process (e.g., concussion, intractable seizure disorder, cancer treatment effects, genetic disorders, inborn errors of metabolism)
          The scope of these criteria is applicable only to neuropsychological testing that is covered by the medical benefit. These criteria do not apply to evaluate or determine educational interventions.
    - Confirmed space-occupying brain lesion including but not limited to the following:
        - Brain abscess;
        - Brain tumors;
        - Arteriovenous malformations within the brain.
    - Dementia or symptoms of dementia such as memory impairment or memory loss (including extrapyramidal disorders such as Parkinson's disease) that is associated with a new onset or progressive memory loss and a decline in at least one of the following cognitive domains (DSM-5):
        - Complex attention;
        - Executive function;
        - Learning and memory;
        - Language;
        - Perceptual-motor;
        - Social cognition.
    - Demyelinating disorders, including multiple sclerosis
    - Intellectual disability or intellectual developmental disorder, when all of the following are present:
        - The intellectual disability or intellectual developmental disorder is associated with a known or suspected medical cause (e.g., traumatic brain injury, in utero toxin exposure, early seizure disorder, sickle cell disease, genetic disorders)
          AND
        - The intellectual disability or intellectual developmental disorder meets all of the following criteria (DSM-5):
            - Deficits in intellectual function, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing;
              AND
            - Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living across multiple environments, such as home, school, work and community;
            - Onset of intellectual and adaptive deficits during the developmental period

          The scope of these criteria is applicable only to neuropsychological testing that is covered by the medical benefit. These criteria do not apply to evaluate or determine educational interventions.
    - Encephalopathy including acquired immunodeficiency syndrome (AIDS) encephalopathy, human immunodeficiency virus (HIV) encephalopathy, hepatic encephalopathy, Lyme disease encephalopathy including neuroborreliosis, Wernicke's encephalopathy, and systemic lupus erythematosus (SLE) encephalopathy.
    - Neurotoxin exposure with at least one of the following:
        - Demonstrated serum levels of neurotoxins
        - Individual with documented significant prenatal alcohol, drug, or toxin exposure
    - Seizure disorder, including patients with epilepsy and patients being considered for epilepsy surgery
    - Stroke
    - Traumatic brain injury (TBI): TBI is defined as a bump, blow, or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

- Neuropsychological testing is unproven and not medically necessary for the following (for more information, see www.unitedhealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Neuropsychological Testing Under the Medical Benefit):
    - Baseline neuropsychological testing in asymptomatic persons at risk for sport-related concussions
    - Computerized neuropsychological testing when used alone for evaluating concussions
    - Neuropsychological testing for the following diagnoses alone without other covered conditions as noted above:
        - Headaches, including migraine headache;
        - History of myocardial infarction;
        - Intermittent explosive disorder.
    - Computerized cognitive testing, such as Mindstreams® Cognitive Health Assessment and BrainCare™.

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REVISION HISTORY

Date	Action/Description
08/2013	• Version 1.
01/2016	• Version 4. Annual review.
01/2017	• Version 5. Annual review.
03/2017	• Version 6, Mid-cycle review. New format.
05/09/2018	• Version 7. Annual review. Added criteria for new benefits: Case Consultation, CFT Interdisciplinary Meeting, and Respite. Replaced

Date	Action/Description
	guideline for Community Based Rehabilitative Services – Child and Adolescent with a guideline for Skills Building/Community Based Rehabilitative Services – Children and Youth. New benefits go into effect on 07/01/2018. New format.
06/12/2018	• Adult and Children's services are grouped together, the two IOPs are grouped, and the services for all populations are grouped. • Revised the titles to remove "Wraparound Service" in the Table of Contents and in the headers for each section. • Revised some language under Skills Building.
9/10/2018	• Added Crisis Response and Family Psychoeducation new LOCG criteria.
01/31/2019	• Removed Substance Use Disorder Guidance as ASAM Criteria have been adopted.
04/22/2019	• New guidelines approved for Crisis Services and Targeted Care Coordination.