Optum

Optum Behavioral Health Solutions
Medicaid State-Specific
Supplemental Clinical Criteria

Idaho Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

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 these Clinical Criteria. 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 Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

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 tele-mental health used to treat mental health conditions and substance use disorders.

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

- An initial Comprehensive Diagnostic Assessment (CDA) needs to be completed; and
- The Member can be adequately and safely treated with outpatient services; and
- Prior to the provision of services, the responsible provider shall complete, update or acquire (if existing) a Comprehensive Diagnostic Assessment (CDA) and a functional assessment tool which is used to guide individualized treatment planning.

Outpatient Continued Stay Criteria

- For continued service, the Clinical Criteria must be met to continue active treatment.

Outpatient Discharge Criteria

- For discharge from service, the Clinical Criteria are no longer met, the Member's condition no longer requires care, or the Member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Adult Services: Crisis Centers

Behavioral Health Crisis is a crisis 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, be 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 Centers provide crisis services to adults in a behavioral health crisis for no more than twenty-three (23) hours and fifty-nine (59) minutes per single episode of care. Crisis centers are not used for housing or shelter.

Admission Criteria

- The member is 18 years or older
  AND
- The member has self-identified that he/she is experiencing a behavioral health crisis.
  OR
- The member's family, informal and formal supports have identified that the member is experiencing a behavioral 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 Stay Criteria

- Crisis Center services are intended to stabilize the member during a behavioral health crisis. Crisis Center service providers practice only within their scope of practice and make referrals as appropriate based on the acuity of the crisis. Crisis Center 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

- The Crisis Center 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.

Adult Services: Adult Peer Support/Recovery Coaching

Adult Peer Support services 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.

Recovery Coaching services are recovery support services provided to members whose primary diagnosis is SUD. The Certified Recovery Coach serves as a personal guide and mentor for participants in recovery, helping to remove barriers and obstacles, linking participants to services, supports, and the recovery community. Following any episodes of drug or alcohol use or lapses in recovery, the Recovery Coach works to achieve quick turnaround in reengaging the individual in treatment and/or recovery support. The efforts of the Recovery Coach decrease substance use, number and severity of relapse episodes, and criminal justice involvement.

The relationship between the Peer Support Specialist/Recovery Coach 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.

Admission Criteria

- The Member has chosen to participate in Peer Support Services.
  AND
- The Member is 18 years of age or older.
  AND
- Services are:
  - Within the scope of the Peer Support Specialist/Recovery Coach'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 to include telehealth when appropriate.
- 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).
- 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).

Continued Stay Criteria

- The initial service criteria are still met, recovery services are being delivered and the services are:
  - Provided and documented by the Peer Support Specialist/Recovery Coach under an individualized recovery plan that is focused on addressing the reasons Peer Support Services are being provided.
  - 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.
  - At a minimum, the Certified Peer Specialist will collaborate with the Member, Member's Family and or Member's authorized representative to formally review the recovery plan every 90 days. However, revisions to the recovery plan will be made whenever there are significant changes in the Member's condition, needs, and preferences or at the request of the Member, Member's Family and or Member's authorized representative.

Discharge Criteria

- 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/Recovery Coach 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.

Adult, Children And Adolescent Services: Presumptive/Qualitative Drug Testing

Presumptive/Qualitative Drug Testing is used when necessary to determine the presence or absence of drugs or a Drug Class. Presumptive/qualitative drug testing is an important part of treatment for substance use disorder (SUD). Presumptive/qualitative drug testing can be used to assess for adherence, persistent substance use, and diversion. Presumptive/qualitative drug testing is used as a therapeutic tool within behavioral health treatment, used to assist in treatment planning, and to therapeutically monitor and support recovery. Presumptive/qualitative drug testing is not covered as part of routine physicals or for legal, criminal justice, employment, or administrative purposes. When a member is participating in a bundled service presumptive/qualitative drug testing is not covered outside of bundled services.
Presumptive/qualitative drug testing is not considered definitive testing that would typically be performed in a laboratory. Presumptive/qualitative drug testing is performed using a method that establishes preliminary evidence regarding absence or presence of drugs or metabolites in a sample, results being expressed in a positive or a negative.

Admission Criteria

- The member has a behavioral health diagnosis, or the member is being assessed for a possible behavioral health diagnosis AND at least one of the following:
  - The member is participating in substance use disorder treatment
  - The member is being assessed for possible substance use disorder
  - The member has an altered mental status
  - The member has a possible overdose

Continued Stay Criteria

- At least one of the following:

- The admission criteria continue to be met, active treatment continues, and evidence-based practices continue to be provided
- Multiple relapses in a given calendar year, requiring multiple treatment starts and episodes of frequent testing

Discharge Criteria

- For discharge from service, the admission criteria are no longer met, the member's condition no longer requires drug testing.

Service Delivery

- Refer to Idaho Medicaid Drug Testing Policy for additional information.

Adult, Children And Adolescent Services: Mental Health –Skills Training And Development (STAD)

Skills Training And Development (STAD) is treatment for members whose functioning is sufficiently disrupted to the extent that it interferes with their daily life as identified by a comprehensive diagnostic assessment and functional assessment tool. Skills training and development is provided in a structured group environment in a mental health clinic setting or an appropriate community setting. The service includes independent or group activities focusing on enhancing and/or developing social, communication, behavior, and basic living skills. All services must be provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment care needs.

Admission Criteria

- Skills training and development is deemed appropriate to treat adults recovering from a Serious and Persistent Mental Illness (SPMI) and or Serious Mental Illness (SMI) who have been assessed to have at least two (2) significant functional needs indicated on the functional assessment tool that are related to the identified SPMI/SMI.
  OR
- Skills training and development is deemed appropriate to treat a youth member identified as having a serious emotional disturbance (SED) and has been assessed to have at least 1 significant functional deficit related to the identified SED.
  AND
- Skills training and development is necessary in order for the member to obtain, apply, and/or when skills require a defined period of reinforcement, of the developmentally age-appropriate skills. Skills training and development addresses a member's ability to function adaptively in the home and community settings. The following functional areas to be assessed are:
  - Vocational/educational
  - Financial
  - Social relationships/support
  - Family
  - Basic living skills
  - Housing
  - Community/legal
  - Health/medical

Continued Stay Criteria

- The provider and member, member's family or member's authorized representative shall conduct an intermittent review of the skills training and development plan as needed to incorporate progress, different goals, or change in service focus. The skills training and development plan should be updated frequently enough to reflect changes in the member's condition, needs and preferences or at the request of the member, member's family or member's authorized representative and the period between reviews shall not exceed 90 calendar days.

Discharge Criteria

- For discharge from service, the admission criteria are no longer met, the member's condition no longer requires skills training and development, and or the member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Adult, Children And Adolescent Services: Behavioral Health Case Management

Behavioral Health 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 or substance use disorder 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. Additionally, Case Management can be provided to members transitioning out of an inpatient or residential treatment. Case Management can be provided up to 180 days prior to the member's discharge from the inpatient or residential facility.

Admission Criteria

- 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.

Continued Stay Criteria

- 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 every 90 days and include an ongoing assessment of the Member's capacity to independently access services.

Discharge Criteria

- The Member can access and/or arrange social services on his/her own without case management.

Adult, Children And Adolescent Services: Crisis Services

Behavioral Health Crisis is a crisis 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, be 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 behavioral 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.

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 behavioral health crisis cannot be resolved telephonically and a higher level of intervention is indicated, then the member will be referred to Crisis Intervention Services and/or Crisis Centers for adult members. 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 behavioral 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 behavioral 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 24 hours following a behavioral health crisis, crisis service providers will follow up telephonically with the Member/member's family to assess member stability and crisis follow-up needs.

Admission Criteria

- The member has self-identified that he/she is experiencing a behavioral health crisis
  OR
- The member's family, informal and formal supports have identified that the member is experiencing a behavioral 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 Stay Criteria

- Crisis services are intended to stabilize the member during a behavioral 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

- 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.

Adult, Children And Adolescent Services: Skills Building/Community Based Rehabilitation Services

Skills Building/Community Based Rehabilitation Services: Focus 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 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

- Skills Building/CBRS is deemed appropriate to treat adults recovering from a Serious and Persistent Mental Illness (SPMI) and or Serious Mental Illness (SMI) who have been assessed to have at least two (2) significant functional needs indicated on the functional assessment tool that are related to the identified SPMI/SMI.
  OR
- Skills Building/CBRS is deemed appropriate to treat a youth Member identified as having a serious emotional disturbance (SED) and has been assessed to have at least 1 significant functional deficit related to the identified SED.
  AND
- Skills Building/CBRS services are necessary for the Member to obtain, apply, and/or when skills require a defined period of reinforcement, of the developmentally age-appropriate skills. Skills Building/CBRS addresses a Member's ability to function adaptively in the home and community settings. The following functional areas to be assessed are:
  - Vocational/educational
  - Financial
  - Social relationships/support
  - Family
  - Basic living skills
  - Housing
  - Community/legal
  - Health/medical

  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 assessment tool. Treatment planning for this service is developed using the teaming approach. The teaming approach is the process in which the independently licensed or Master's level clinician under Supervisory Protocol, Skills Building paraprofessional, the Member, Member's Family and or Member's authorized representative, work together to develop an individualized Skills Building/CBRS treatment plan. The purpose of this process is to ensure that the Skills Building paraprofessional is receiving adequate supervision in creating an appropriate treatment plan for the Member. This process also allows the supervising clinician to be able to gain a clear, clinical understanding of the case he or she is overseeing. The treatment plan is approved by the independently licensed clinician and confirmed with their signature and title.
  AND
- The skill building/CBRS treatment plan must be developed prior to the provision of services and prior to the submission of the service request form.
- See provider manual for more information
  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)/modality for each skill/knowledge or resource objective related to the specific functional need.
  - The provider responsible for providing the intervention, and the amount, frequency and expected duration of service.
  - The skills building treatment plan must include the Member/Member's family and or the Member's authorized representative signature on the document indicating his/her agreement with treatment plan goals and objectives and his/her participation in its development.

Continued Stay Criteria

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

- Treatment plan updates should reflect findings of functional assessment tool updates.

- 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.

Discharge Criteria

For discharge from service, the admission criteria are no longer met, the Member's condition no longer requires skills building/CBRS, and or the Member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Adult, Children and Adolescent Services: 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 an evidence-based practice and guides 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 can 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 can 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

- A youth Member with a serious emotional disturbance (SED).
  OR
- Adult Members with Serious and Persistent Mental Illness (SPMI) and or Serious Mental Illness (SMI)
  AND
  The Member, Member's Family and or Member's authorized representative have chosen to participate in Family Psychoeducation.

Continued Stay Criteria

- Clinical best practices are being provided with enough 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.

Discharge Criteria

- For discharge from service, the admission criteria are no longer met, the Member's condition no longer requires care, and or the Member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Child and Adolescent Services: Modification and Consultation

Behavior Modification and Consultation– Children and Adolescents: Behavior modification and consultation (BMC) is the design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. These interventions are based on scientific research and the use of direct observation, measurement, and functional analysis. Behavioral strategies are used to teach the Member alternative skills to manage targeted behaviors across various environments. Behavior modification providers may provide this service at any time and any setting appropriate to meet the Member's needs, including home, school, and community. For successful outcomes, modified behaviors must be reinforced by the child/adolescent's parents, family, and other natural supports. All treatment, care and support services must be provided in a context that is child centered, family-focused, strengths based, culturally competent and responsive to each child's psychosocial, developmental, and treatment care needs.

Admission Criteria

- A Member that is diagnosed with a serious emotional disturbance (SED).
  - A person is identified as having SED if they have both a DSM diagnosis and a functional impairment as identified by the Child and Adolescent Needs and Strengths (CANS) tool.

  AND
- The results of the Member's standardized adaptive or functional behavioral assessment indicate maladaptive behaviors and functional limitations that significantly impact the Member's ability to function successfully in home, community and/or school settings

  AND
- The family is engaged with treatment planning and willing to actively participate in the Member's behavior modification and consultation treatment.

  AND
- The Member is not actively engaged in Skills Building/Community Based Rehabilitative Services (CBRS).

  AND
- Services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA) are not covered (e.g., a 1:1 aid in the school setting). BMC services do allow for coordination of services and would cover services such as, teacher training, meetings with school personnel, and observations in the school setting.

  AND
- BMC services are the least restrictive and most appropriate services for the Member. If there are other less restrictive or more appropriate options available those should be utilized, i.e. cognitive behavior therapy, dialectical behavior therapy, etc.

  AND
- The Member is not receiving duplicate services

  AND
- The Member must have the following documents submitted as a part of the prior authorization process:
  - A completed comprehensive diagnostic assessment (CDA) indicating medical necessity which has been completed by a psychiatrist, physician, psychologist, independently licensed clinician or master's level clinician under supervisory protocol
  - Justification/rational for referral/non-referral for a functional behavioral assessment and possible BMC services
- The documentation should include:
  - A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;
  - Direct observation of the Member, including but not limited to, assessment of current functioning in the areas of social and communicative behaviors, adaptive skills, cognitive skills, and play or peer interactive behaviors;

- If there is any lack of clarity about the primary diagnosis, comorbid conditions or the medical necessity of services requested, the following categories of assessment as appropriate to the individual Member should be included with the CDA:
  - Autism specific assessments.
  - Assessment of general psychopathology.
  - Cognitive assessment.
  - Assessment of adaptive behavior.
- When providers of multiple disciplines are involved in assessment (e.g., occupational therapy, physical therapy), coordination among the various professionals is required
- A valid Diagnostic and Statistical Manual of Mental Disorders, (DSM) V (or current edition) diagnosis;
- Recommendations for an additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

Once approved for an BMC assessment the provider must submit the below for BMC treatment review:
- A treatment plan based on behavior and/or skills based assessments, further detailed in the treatment planning section.
- The results of the behavior and/or skills based assessments rendered by the qualified supervisor (see provider qualifications).

Treatment Planning

- A standardized functional behavior assessment is used to maximize the effectiveness and efficiency of behavioral support interventions (Myers and Johnson, reaffirmed 2014). The assessment may incorporate information such as interviews with caregivers, structured rating scales, direct observation data, and attention to coexisting medical conditions (Behavior Analyst Certification Board, 2014)
- The type of standardized functional behavior assessment used is determined by Member's needs and consent, environmental parameters, and other contextual variables. (This is not the Child and Adolescents Needs and Strengths (CANS) assessment)
- When an individual displays maladaptive behavior it is recommended the credentialed provider complete a functional behavior assessment to better inform treatment planning. (See provider qualifications)
- Targets include areas such as the following:
  - Social communication skills
  - Social language skills
  - Social interaction skills
  - Restricted, repetitive patterns of behavior, interests, or activities
  - Self-injurious, violent, destructive, or other maladaptive behavior
- A credentialed provider is identified to provide treatment. (See provider qualifications)
- Outcome-oriented interventions targeting specific baseline behaviors are identified in a treatment plan describing the frequency, intensity, duration, and progress that will be continuously updated.
  - Treatment planning should occur as appropriate per Member's given symptoms and following best practice guidelines.
  - The treatment plan must address how the parents/guardians will be trained in management skills that can be generalized to the home.
    - Parent/guardian training is an expectation. In the rare circumstance that parent/guardian is unable to participate in training; the documentation must reflect the reason and identify an alternate plan to provide management skills in the home.
- The treatment goals and objectives must be comprehensive and clearly stated.
- The treatment plan is in sync with the child's person-centered service plan and or Individualized Education Plan (IEP) if applicable.
- All components of the Member's care are tracked and updated throughout the duration of services

Treatment

- BMC intervention must include the following elements:
  - Target specific needs related to imitation, attention, motivation, compliance and initiation of interaction, and the specific behaviors that are to be incrementally taught and positively reinforced tie to objective and quantifiable treatment goals that have baseline data, measurable progress, and projected timeframes for completion. Include the

child's parents in parent training and the acquisition of skills in behavior modification to promote management of skills within the home
    - Train family Members and other caregivers to manage problem behavior and interact with the child in a therapeutic manner
    - As indicated, include psychotherapy (e.g., cognitive behavioral therapy) for higher functioning Members to treat conditions such as anxiety and anger management
    - Have an appropriate level of intensity and duration driven by factors such as:
        - Treatment goals that relate to and include how skills will be generalized and maintained across people and environments
        - Changes in the targeted behavior(s) / response to treatment
        - The demonstration and maintenance of management skills by the parents and caregivers.
        - Whether specific issues are being treated in a less intensive group format (e.g., social skills groups)
    - The Member's ability to participate in BMC given attendance at school, daycare, or other treatment settings;
    - The impact of co-occurring behavioral or medical conditions on skill attainment;
    - The Member's overall symptom severity; and
    - The Member's progress in treatment related to treatment duration.
- Parent/Caregiver support is expected to be a component of BMC services, as they will need to provide additional hours of behavioral interventions. Parents or caregivers must be involved and engaged in the training and follow through on treatment recommendations beyond that provided by licensed or certified practitioners. Parent support groups are considered not medically necessary.
- Services are intensive and may be provided daily, but ordinarily will not exceed 8 hours per day or 40 hours per week inclusive of other interventions. These hours of service also consider other non-behavioral services such as school, speech, and occupational therapies, generally covered by other entities.

Coordination of Care

- If applicable, documentation of communication and coordination with other service providers and agencies, (i.e. day care, preschool, school, early intervention services providers) and/or other care providers (i.e. occupational therapy, speech therapy, physical therapy and any other applicable providers) to reduce the likelihood of unnecessary duplication of services. Documentation should include the following:
    - Types of therapy provided
    - Number of therapies per week
    - Behaviors/needs targeted
    - Progress related to the treatment/services being provided
    - Measurable criteria for completing treatment with projected plan for continued care after discharge from BMC services
    - Total number of days per week and hours per day of direct services to child and parents or caregivers to include duration and location of requested BMC services
    - Dates of service requested
    - Licensure, certification, and credentials of the professionals providing BMC services to the child
    - Evidence that parents and/or caregivers have remained engaged in the treatment plan, following all appropriate treatment recommendations
    - Detailed description of interventions with the parent(s) or caregiver(s), including:
        - Parental or caregiver education, training, coaching and support
        - Overall parent or caregiver goals including a brief summary of progress. As part of the summary of progress the information should also include percentage of planned sessions attended
        - Plan for transitioning BMC services identified for the Member to the parents or caregivers.

Continued Stay Criteria

- With each medical necessity review for continued BMC services, an updated treatment plan and progress reports will be required for review, including all of the following documentation:
    - There is a reasonable expectation on the part of the treating clinician that the Member's behavior and skill needs will continue to improve to a clinically meaningful extent, in at least two settings (home, school, community) with BMC services
    - Therapy is not making the symptoms or behaviors persistently worse

- Progress is assessed and documented for each targeted symptom and behavior, including progress toward defined goals, and including the same modes of measurement that were utilized for baseline measurements of specific symptoms and behaviors.
- The treatment plan and progress report should reflect improvement from baseline in skill needs and problematic behaviors using validated assessments of adaptive functioning.
- Parent/Caregivers are involved and making progress in their own development of behavioral interventions
- The treatment plan should reflect a plan to transition services in intensity over time.
- When there has been inadequate progress with targeted symptoms or behaviors, or no demonstrable progress within a six-month period, or specific goals have not been achieved within the estimated timeframes, there should be an assessment of the reasons for inadequate progress or not meeting the goals, and treatment interventions should be modified or changed in order to attempt to achieve adequate progress. Documentation of such an assessment and subsequent treatment plan change(s) must include:
  - Increased time and/or frequency working on targets
  - Change in treatment techniques
  - Increased parent/caregiver training
  - Identification and resolution of barriers to treatment effectiveness
  - Any newly identified co-existing disorder (e.g., anxiety, psychotic disorder, mood disorder)
  - Goals reconsidered (e.g., modified or removed)
- When goals have been achieved, either new goals should be identified that are based on targeted symptoms and behaviors that are preventing the child from adequately participating in age-appropriate home, school or community activities, or that are presenting a safety risk to self, others, or property; or the treatment plan should be revised to include a transition to less intensive interventions.

Discharge Criteria

- When any of the following criteria are met the child will be considered discharged and any further BMC services will be considered not medically necessary
- Documentation that the child demonstrates improvement from baseline in targeted skill needs and behaviors to the extent that goals are achieved, or maximum benefit has been reached
- Documentation that there has been no clinically significant progress or measurable improvement for a period of at least 3 months in the child's behaviors or skill needs in any of the following measures:
  - Adaptive functioning
  - Communication skills
  - Language skills
  - Social skills
  - The treatment is making the skill needs and/or behaviors persistently worse
  - The child is unlikely to continue to benefit or maintain long term gains from continued BMC services
- Parents and/or caregivers have refused treatment recommendations or are unable to participate in the treatment program and/or do not follow through on treatment recommendations to an extent that compromises the effectiveness of the services.

Documentation Requirements

- BMC providers are required to have a separate record for each Member that contains the following documentation:
  - Comprehensive diagnostic assessment
  - All necessary demographic information
  - Complete developmental history and educational assessment
  - Functional behavioral assessment including assessment of targeted risk behaviors
  - Behavioral/medical health treatment history including but not limited to:
    - known conditions
    - dates and providers of previous treatment
    - current treating clinicians
    - current therapeutic interventions and responses
  - Individualized BMC treatment plan and all revisions to the BMC treatment plan, including objective and measurable goals, as well as parent training
  - Daily progress notes including:

- place of service
- start and stop time
- who rendered the service
- the specific service (e.g., parenting training, supervision, direct service)
- who attended the session
- interventions that occurred during the session
- barriers to progress
- response to interventions

- All documentation must be legible
- All documentation related to coordination of care
- All documentation related to supervision of paraprofessionals
- If applicable, a copy of the child's Individualized Education Plan (IEP)
- If applicable, progress notes related to Early Intervention Plan or Pre-school/Special Education Program or allied health services
- Certification and credentials of the professionals providing the BMC services.

Behavior Modification and Consultation - Provider Qualifications

- A Master- or Doctoral-level provider that is a Board-Certified Behavior Analyst (BCBA)
- An independently licensed master's level or higher behavioral health clinician who has attested to having enough expertise with additional training in applied behavior analysis (ABA)/intensive behavior therapy six (6) months of supervised experience or training in the treatment of applied behavior analysis (ABA)/intensive behavior therapies
- A Licensed Psychologist provided that the services provided are within the boundaries of the Licensed Psychologist's education, training, and competence and who has attested to having sufficient expertise with additional training in applied behavior analysis (ABA)/intensive behavior therapy and six (6) months of supervised experience or training in the treatment of applied behavior analysis (ABA)/intensive behavior therapies
- A bachelor level or higher provider credentialed as a Board-Certified Assistant Behavior Analyst (BCaBA) under the direct supervision of a BCBA or an independently licensed behavioral clinician who has attested to having enough expertise with additional training in applied behavior analysis (ABA)/intensive behavior therapy.
- Behavior technician provider must be at least 18 years of age, have a high school diploma or equivalent, current registration as a Registered Behavior Technician (RBT) from the national Behavior Analyst Certification Board, or alternative national board certification, and receive appropriate training and supervision by BCBAs, BCaBA or an independently licensed behavioral health clinician who has attested to having sufficient expertise with additional training in applied behavior analysis (ABA)/intensive behavior therapy. Paraprofessional interventions must be directly supervised with the child present at least 1 hour per month ordinarily not to exceed 1 hour for every 10 hours of direct care provided
- A master's level or higher provider who is a service extender registered with the Idaho Bureau of Occupational licenses to be working with a specified psychologist. A service extender delivers psychological services under the direct supervision of a licensed psychologist provided that the services provided are within the boundaries of the Licensed Psychologist's education, training, and competence.

Child and Adolescent Services: Day Treatment

Day Treatment – Children and Adolescents: Day Treatment is a structured program available to children and adolescents exhibiting severe needs that can be addressed and managed in a level of care that is less intensive than inpatient psychiatric hospitalization, partial hospitalization or residential treatment, but requires a higher level of care than intensive or routine outpatient services. These services typically include a therapeutic milieu that may include skills building, medication management, and group, individual and family therapy. Day treatment programs are offered 4-5 days per week and may include after hours and weekends. There is a minimum of 3 hours per day and maximum of 5 hours per day. Day Treatment providers will ensure consistent coordination and communication with other agencies working with the child/adolescents, including coordination with the schools. All treatment, care and support services must be provided in a context that is child centered, family-focused, strengths based, culturally competent and responsive to each child's psychosocial, developmental, and treatment care needs.

Admission Criteria

- A Member with a serious emotional disturbance (SED) and is exhibiting severe needs that can be addressed and managed in a level of care that is less intensive than inpatient psychiatric hospitalization, partial hospitalization or residential treatment, but requires a higher level of care than intensive or routine outpatient services.
  AND
- The Member is not receiving duplicate services.
  AND
- The Comprehensive Diagnostic Assessment (CDA) and the Child and Adolescent Needs and Strengths (CANS) functional assessment tool have been completed/ acquired and or updated and the findings indicate severe needs and acuity for this level of treatment.
  AND
- Assessment and diagnosis and/or treatment planning requires observation and face-to-face interactions at least 3 hours per day, 4-5 days per week and updates and changes are made to the treatment plan every 30 days or as appropriate when there is a change in clinical condition.
  AND
- 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 to help the Member transition back into the community.
  AND
- The Member has a documented crisis/safety plan.
  AND
- There is documentation of communication and coordination with other service providers and agencies, (i.e. schools, education service providers) and/or other health care providers.
  AND
- There is Member engagement and support, which requires extended interaction between the Member and the program to coordinate transition back into the community.

Continued Stay Criteria

- The provider and Member, Member's Family or Member's authorized representative shall conduct an intermittent review of the day treatment plan as needed to incorporate progress, different goals, or change in service focus. The day treatment plan should be updated frequently enough to reflect changes in the Member's condition, needs and preferences, or at the request of the Member, Member's Family or Member's authorized representative and the period of time between reviews shall not exceed 30 calendar days
  AND
- The CANS functional assessment tool must be updated at least every 90 days or as needed, and findings indicate severe needs and acuity for this level of treatment.
  AND
- The Member does not require a more or less intense level of care.
  AND
- Active engagement and participation are occurring, and continued progress toward goals is expected. Progress in relation to goals is clearly evident, measurable, and described in observable terms.
  AND
- If objectives have not yet been achieved, documentation supports continued interventions.
  AND
- There has been coordination with school services to reintegrate children/adolescent/youth back into school environment.

Discharge Criteria

- For discharge from service, the admission criteria are no longer met, the Member's condition no longer requires day treatment, and or the Member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Intensive Home and Community Based Services – Children and Adolescents:

Intensive Home and Community-Based Services (IHCBS) programs are provided to children and adolescent Members who are experiencing social, emotional, and behavioral difficulties and need more intensive services to increase stability across settings and help prevent out-of-home placement. IHCBS include a flexible array of services to meet the assessed needs, including crisis response and intervention. Delivery of services can be centered, but not limited to, on one of the following therapeutic approaches: Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), or Multi-systemic Therapy (MST). All treatment, care and support services must be provided in a context that is individualized, family-centered, strength based, culturally competent and responsive to each child and adolescents' psychosocial, developmental, and treatment care needs.

Admission Criteria

- A Member with a serious emotional disturbance (SED)
  AND
- There are acute clinical changes in the Member's signs and symptoms, and/or psychosocial and environmental factors (i.e., the factors leading to admission) which suggest that the Member is at risk for out-of-home care or hospitalization, or otherwise requires ongoing involvement with multiple systems due to high-risk behaviors. The Member's current condition can be safely, efficiently, and effectively assessed and/or treated in this setting. Examples of factors that put the Member at risk include:
  - Complex and persistent behavioral health conditions with/without co-occurring medical conditions.
  - Behavioral health conditions coupled with abuse, neglect, or other forms of trauma.
  - Behavioral health conditions coupled with delinquency, truancy, or running away.

  AND
- 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.
- AND
- The Member and his or her parent/caregiver/guardian are willing to accept and cooperate with IHCBS program, including the degree of parent/caregiver/guardian participation outlined in the treatment plan.

  OR
- The Member meets the target criteria for the proposed IHCBS program:
  - Functional Family Therapy (FFT): Member is aged 11-18, and has ongoing trouble regulating his or her emotions/behavior as a result of trauma.
  - Multidimensional Family Therapy (MFT): Member is aged 6-17, and presents with a Substance-Related Disorder, a co-occurring Substance-Related Disorder and other behavioral health condition, or a Substance-Related Disorder along with other behavior problems such as delinquency.
  - Multi-Systemic Therapy (MST): (All of the following criteria are necessary for admission):
    - Member is aged 12-17
    - Member is a chronic or violent juvenile offender
    - is at risk of out-of-home placement or is transitioning back from an out- of-home setting
    - Externalizing behavior symptomology resulting in a DSM diagnosis of Conduct Disorder or other diagnosis consistent with such symptomology (ODD, Behavior Disorder NOS, etc.)
    - Ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems
    - Less intensive treatment has been ineffective or is inappropriate
  - Therapeutic Behavioral Services (TBS): Member is aged 5-18 with serious emotional disturbance. The member is at risk of being considered for any higher-level placement, psychiatric hospitalization, or has other high-risk behaviors that would benefit from behavioral support services.

Continued Stay Criteria

- The severity of the Member's conditions and needs continue to require this level of service.

AND

- Service planning is individualized to the Member and his or her family's changing condition; realistic and specific goals and objectives are stated; the mode, intensity, and frequency of treatment are consistent with best known evidence-based practice(s).

AND

- Active participation is occurring, and continued progress toward goals is expected. Progress in relation to goals is clearly evident, measurable, and described in observable terms.
  - If objectives have not yet been achieved, documentation supports continued interventions.

AND

- The admission criteria cited in the previous section otherwise continue to be met.

OR

- Multi-systemic Therapy (MST): (All of the following criteria are required for continuing treatment at this level of care):
  - Treatment does not require a more intensive level of care
  - Treatment plan has been developed, implemented, and updated, based on the Member's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated
  - Progress is clearly evident in objective terms, but goals of the treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident
  - Family/caregivers are actively involved in treatment, or there are active, persistent efforts being made that are expected to lead to engagement in treatment

Discharge Criteria

- The continued stay criteria are no longer met. Examples include:
  - The Member's documented treatment goals and objectives have been successfully met.
  - The Member meets criteria for a less/more intensive level of care.
  - The Member or his or her parent/caregiver/guardian is unwilling or unable to participate in services.

OR

- Member is not making progress or requires a higher-level of care

OR

- Multi-systemic Therapy (MST): (The following criteria indicate that the child/adolescent no longer meets medical necessity criteria for MST):
  - Member's documented treatment plan goals have been substantially met, including discharge plan
  - Member and/or family no longer meets Continued Stay Criteria, or meets criteria for a less or more intensive level of care
  - Member and/or family have not benefited from MST despite documented efforts to engage and there is no reasonable expectation of progress at this level of care despite treatment

Child and Adolescent Services: Family Support Services

Family Support Services provide assistance to caregivers who are caring for a youth who have been identified as having a serious emotional disturbance (SED) 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, with lived experience and with specialized training have acquired an understanding of another parent's situation via the shared emotional and psychological challenges of raising a child with a SED. 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. 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.

Admission Criteria

- A youth Member has been identified as having serious emotional disturbance (SED).
  AND
- The youth Member's presenting signs, symptoms and environmental factors indicate their needs can be adequately and safely treated with outpatient services.
  AND
- The youth Member/Member's family has chosen to participate in family support services.
  AND
- 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.

Continued Stay Criteria

- The initial service criteria are still met, recovery services are being delivered and the services are:
  - Provided and documented by the Certified Family Support Partner following an individualized recovery plan that is focused on addressing the reasons services are being provided.
  - The factors leading the need for 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.
  - At a minimum, CFSP will collaborate with the Member, Member's Family or Member's authorized representative to formally review the recovery plan at minimum of every 90 days. However, revisions to the recovery plan will be made whenever there are significant changes in the Member's condition, needs, and preferences or at the request of the Member, Member's Family or Member's authorized representative
  - The CFSP is working toward the following outcomes with the family:
    - The ability to identify and use wellness tools.
    - 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

- For discharge from family support service, the admission criteria are no longer met, the Member's condition no longer requires care, and or the Member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Child and Adolescent 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.

The YES Program federal requirements state that a Member must use a YES Program (1915(i)-specific) service one time per plan year and include it on their Person-Centered Service Plan (PCSP) in order to maintain eligibility under the YES Program. Currently, the only YES Program (1915(i)-specific) service is Respite.

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

- The Independent Assessor has completed an assessment and determined the youth has SED
  AND
- The Member is eligible for Medicaid 1915(i) State Plan Amendment.
  AND
- The need for respite is documented on the Member's person-centered service plan.
  AND
- The Member/Member's family is willing to receive respite and willing to be assessed by a treating professional.
  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 childcare 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).

Continued Stay Criteria and Discharge Criteria

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

Child and Adolescent Services: Youth Support

Youth Support - Children and Adolescents: Youth Support Services exist under the umbrella of Peer Support Services. Youth support services are provided to children and adolescents from ages 12 through 17 years old (up to their 18th birthday). Youth support services assist and support the adolescent in understanding their role in accessing services, becoming informed consumers of services and self-advocacy. Youth support may include, but not limited to, mentoring, advocating, and educating through youth support activities individually or in groups. All support services must be provided in a context that is youth

centered, family-focused, strengths based, culturally competent and responsive to each adolescent's psychosocial, developmental, and treatment care needs.

Admission Criteria

- A youth Member with a serious emotional disturbance (SED).
  AND
- The member is at least 12 years-old and under 18 years-old.
- The youth Member's presenting signs, symptoms and environmental factors indicate their needs can be adequately and safely treated with outpatient services.
  AND
- The youth Member has chosen to participate in youth support.

Continued Stay Criteria

- The Member does not require a more or less intense level of care. AND
- The member is at least 12 years-old and under 18 years-old.
  AND
- The Member is engaging, actively participating, and is making progress towards goals identified in the youth support plan.

Discharge Criteria

- For discharge from youth support, the admission criteria are no longer met, the Member's condition no longer requires youth support, and or the Member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Adult, Children And Adolescent Services: Mental Health Intensive Outpatient Program (IOP)

Optum Idaho and the provider network use the Level of Care Utilization System (LOCUS), the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and or the Early Childhood Service Intensity Instrument (ECSII). To guide service delivery, level of care placement for Intensive Outpatient Programs (IOP) for adult, children, and adolescent members.

Adult, Children And Adolescent Intensive Outpatient Program (IOP): Mental Health IOP 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.

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.

Service Delivery

- See: Optum Idaho Provider Manual
  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.

Adult, Children And Adolescent Services: Mental Health Partial Hospitalization Program (PHP)

Optum Idaho and the provider network use the Level of Care Utilization System (LOCUS), the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and or Early Childhood Service Intensity Instrument (ECSII) to guide service delivery, level of care placement for Mental Health Partial Hospitalization Program (PHP) for adult, children and adolescent members.

Partial Hospitalization can be used to treat mental health conditions or substance use disorders, or both, i.e., co-occurring conditions. Partial Hospitalization is a facility-based, structured bundle of services for participants whose symptoms result in severe personal distress and/or significant psychosocial and environmental issues. Partial Hospitalization provides not only behavioral health treatment, but also the opportunity to practice new skills. Services for adolescents are offered separately from services for adults, and each program and its staff must meet the certification and credentialing criteria of the Idaho Department of Health and Welfare. Services must be delivered under the supervision of a licensed physician. In compliance with EPSDT, this service is covered for children through the month of their twenty-first (21st) birthday when medically necessary. Partial Hospitalization is appropriate for participants who are experiencing symptoms that can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but who require a higher level of care than routine outpatient or other intensive services. This service may function as a step-down option from psychiatric hospitalization or residential treatment and may also be used to prevent or minimize the need for a more intensive level of treatment. A participant may be admitted to the program when the participant cannot be safely and appropriately treated in a less restrictive level of care. Partial Hospitalization, MH/SUDs, is delivered a minimum of twenty (20) hours per week for adults or children/adolescents.

Partial Hospitalization must offer to include any of the following component services of the bundle:
- Individual, group, and family psychotherapy and education focused on recovery
- Evidence-informed practices such as group therapy, cognitive behavioral therapy (CBT), motivational interviewing, and multidimensional family therapy
- Psychiatric evaluations and medication management
- Substance use screening and monitoring, if appropriate
- Transition management and discharge planning
- 24-hour crisis coverage, including response and interventions outside of the program setting
- Initial and ongoing risk assessments

Adult, Children And Adolescent Services: Substance-Related Disorders: Opioid Treatment Program (OTP)

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.

Adult, Children And Adolescent Services: Substance-Related Disorders: Partial Hospitalization Program (PHP)

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.

A qualifying DSM-5 diagnosis is required for this service, clinical talk

Children And Adolescent Services: Targeted Care Coordination

Targeted Care Coordination – Children and Adolescents: Targeted Care Coordination (TCC) is the process that assists youth and their family to locate, coordinate, facilitate, provide linkage, advocate for, and monitor the mental and physical health, social, educational, and other services as identified through a child and family teaming process that includes assessment and reassessment of needs and strengths. Targeted care coordination occurs through face to face or telephonic contact and is not intended to be duplicative of any other service. Targeted care coordination services vary in intensity, frequency, and duration in order to support the Member's ability to access, coordinate, and utilize services and social resources that support the Member to reach the goals on their coordinated care plan. Targeted care coordination can be delivered as a community-based service or in the outpatient clinic setting. All treatment, care, and support services must be provided in a context that is child-centered, family-focused, strengths-based, culturally competent, and responsive to each child's psychosocial, developmental, and treatment care needs.

Admission Criteria

- 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 Stay Criteria

- For continued service, the admission criteria continue to be met, active treatment continues, and evidence-based practices continue to be provided.

Discharge Criteria

- For discharge from service, the admission criteria are no longer met, the Member's condition no longer requires targeted care coordination, and or the Member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Adult Services, Children And Adolescent Services: Substance-Related Disorders: Intensive Outpatient Services (IOP)

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.

Health Behavior Assessment And Intervention

Health Behavior Assessment And Intervention (HBAI) services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. The member's primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. Health behavior assessment includes evaluation of the member's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Assessment is conducted through health focused clinical interviews, observation, and clinical decision making. Health behavior intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active member/family engagement and involvement (APA, 2020).

Health Behavior Assessment has **three** required elements that must be performed and documented:

- 1) Health-focused clinical interview: The qualified health care professional (QHP) conducts the face-to-face health-focused clinical interview with the member that may assess multiple domains. Collateral interviews are conducted as appropriate. When it precedes a health behavior intervention, the clinical assessment would determine the type(s) of intervention that would best benefit the member.
- 2) Behavioral observations: The QHP evaluates how the member is responding throughout the health-focused clinical interview through direct behavioral observation.
- 3) Clinical decision making: The QHP integrates information learned prior to the interview (record review, discussions with other health care providers) with information gained during the health-focused clinical interview and behavior observations to formulate the case conceptualization/clinical impressions, established or suspected medical diagnoses, any additional diagnoses determined by the QHP, and treatment recommendations.

Admission Criteria

- The Health Behavioral Assessment or Re-Assessment service may be considered reasonable and necessary for the member who meets all the following criteria:
  - The member has an established or suspected underlying physical illness or injury and the purpose of the assessment or re-assessment is not primarily for the diagnosis or treatment of mental illness.
  - There are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury.
  - The member is alert, oriented, and has the capacity to understand and to respond meaningfully during the face-to-face encounter.
  - The member has an established or suspected underlying physical illness or injury needing a health behavior evaluation and/or intervention to successfully manage their physical illness and activities of daily living.
  - The member can be referred from a medical or mental health care provider, or self-referred to seek assistance in addressing the role of psychological and/or behavioral factors affecting an underlying physical health condition.

Continued Stay Criteria

- In addition to meeting all the criteria stated above, medical necessity for re-assessment must be further established through documentation of one of the following:
  - Change in the mental or medical status warranting re-evaluation.
  - Specific concern from the primary medical provider or member of medical team.
  - Need for re-assessment as part of the standard of care.
  - Change in providers; or
  - At least a 6-month period of time has elapsed since the last assessment.

Health Behavior Intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active member/family engagement and involvement. Evidence-based health behavior interventions address psychological/behavioral factors that can be influencing a person's medical condition and consist of various types of treatment interventions.

Admission Criteria

- The health behavioral intervention services may be considered reasonable and necessary for the member who meets all of the following criteria:
  - The member has an underlying physical illness or injury;
  - Specific psychological intervention(s) and member outcome goal(s) have been clearly identified and documented
  - Psychological intervention is necessary to address:
    - Non-adherence with the medical treatment plan, or
    - The psychological and/or psychosocial factors associated with a newly diagnosed physical illness, or an exacerbation of an established physical illness, when such factors affect:
      - symptom management and expression
      - health-promoting behaviors
      - health-related risk-taking behaviors
      - overall adjustment to medical illness.

- There are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury;
- The member is alert, oriented and has the capacity to understand and to respond meaningfully during the intervention service.

Continued Stay Criteria

- Member continues to meet the criteria as stated above.

HBAI Discharge Criteria

- For discharge from service, the admission criteria are no longer met, the member's condition no longer requires HBAI.

Psychological and Neuropsychological Testing

Testing Services: Psychological and Neuropsychological Testing (Please apply the American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) Please visit ProviderExpress.com.

References

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Idaho Health and Welfare Behavioral Health Standards Manual. (2015). Provision of Family Support Services and Certified Family Support Partners.

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Jeff D. Settlement. (2019).State of Idaho, Administrative Code. IDAPA 16.03.09.011, Definitions I-O.

State of Idaho, Administrative Code. IDAPA 16.03.09.880-889. EPSDT Services.

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Revision History

Date	Summary of Changes
08/2013	Version 1.
08/2014	Version 2. Annual review.
08/2015	Version 3. Annual review.
01/2016	Version 4. Annual review.
01/2017	Version 5. Annual review.
03/2017	Version 6. Mid-cycle review. New format.

Date	Summary of Changes
05/2018	Version 7. Annual review. Added criteria for new benefits: Case Consultation, CFT Interdisciplinary Meeting, and Respite. Replaced 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.
06/2018	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.
09/2018	Added Crisis Response and Family Psychoeducation new LOCG criteria.
01/2019	Removed Substance Use Disorder Guidance as ASAM Criteria have been adopted.
04/2019	Jeff D. and YES revisions
05/2019	Jeff D. and YES revisions
12/2019	Edits due to LOCUS/CASII/ECSII adoption.
1/2020	Added Crisis Centers, Recovery Coaching and Partial Hospitalization Programs (PHP)
3/2020	Added Skills training and Development
10/2020	Added Presumptive/Qualitative Drug Testing
12/2020	Added OTP and APA Psychological Testing Guidelines
11/2021	Updated CASII to CALOCUS-CASII
01/2022	Annual Review – Updated Youth Support
07/2022	Addition of TBS
07/2023	IHCBS Revisions
11/2023	Alignment with Provider Manual
01/2024	Annual Review