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®. 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. 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.

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1 Optum is a brand used by United Behavioral Health and its affiliates.
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 the information collected by the provider following evaluation and treatment planning described in the Common Best Practices.

- The member’s condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of the member’s condition requires the intensity and scope of services provided in the proposed level of care.
- Co-occurring behavioral health and medical conditions can be safely managed in the proposed level of care.
- Services are medical necessary. Rule 59G-1.010 (166), Florida Administrative Code defines “medically necessary” or “medical necessity” as follows: “The medical or allied care, goods, or services furnished or ordered must meet the following conditions: 1) be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain 2) be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs 3) be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational  4) reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide  5) be furnished in a manner, not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services medically necessary or a covered service.”
- There is a reasonable expectation that service(s) will improve the member’s presenting problems.
  - Improvement of the member’s condition is indicated by the reduction or control of the signs and symptoms that necessitated treatment in a level of care.
  - Improvement in this context is measured by weighing the effectiveness of treatment against the evidence that the member’s signs and symptoms will deteriorate if treatment in the current level of care ends.

**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.
- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.
- Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.
- 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 from 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.

**CLUBHOUSE**

CLUBHOUSE services are structured, community-based group services provided in a group rehabilitation service setting. These services include a range of social, educational, pre-vocational and transitional employment rehabilitation training in a group rehabilitation service setting utilizing behavioral, cognitive, or supportive interventions to improve a member’s potential for establishing and maintaining social relationships and obtaining occupational or educational achievements.

A clubhouse group service is designed to strengthen and improve the recipient’s interpersonal skills, and provide psychosocial therapy toward rehabilitation that emphasizes a holistic approach focusing on the member’s strengths and abilities to promote recovery from mental illness. This service is primarily rehabilitative in nature, using a wellness model that offers a setting to restore independent living skills. These services are designed to assist the member in eliminating the functional, interpersonal, and environmental barriers created by their disabilities and to restore social skills for independent living and effective life management. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment focusing on maximum recovery and independence.

**Admission Criteria**

- See Common Admission Criteria
  - The member has a mental health diagnosis and is at least 16 years of age.
  - The member exhibits psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, prevocational, and educational functioning.

**Continuing Stay Criteria**

- See Common Continuing Stay Criteria

**Discharge Criteria**

- See Common Discharge Criteria
Clinical Best Practices

- See Common Clinical Best Practices

The provider collects information from the member and other sources about the following:
  - The member’s vocational/educational, social relationship, and independent living goals;
  - The member’s current psychiatric evaluation.

The provider and member use the findings of the initial evaluation to develop an activity plan as close to the date the member accessed Clubhouse, but no later than 1 week after accessing Clubhouse.
  - Members at their choice are involved in writing the records reflecting their participation in Clubhouse.
  - Records are signed by the provider and member.

- The activity plan includes the following:
  - The member’s vocational/educational, social relationship and independent living goals;
  - The skills, knowledge, activities or other interventions that will be used for each goal;
  - Activities needed to improve the member’s engagement such as motivational enhancement or learning activities;
  - The plan to coordinate Clubhouse services with the member’s behavioral health provider and other service providers.

- Documentation includes at least a daily progress note that addresses each service provided.
- A formal review of the treatment plan must be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur.

PSYCHOSOCIAL REHABILITATION

PSYCHOSOCIAL REHABILITATION services are intended to restore a member’s skills and abilities essential for independent living. Activities include: development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services. This service combines daily medication use, independent and social skills training, housing services, prevocational and transitional employment rehabilitation training, social support, and network enhancement to members and their families.

These services are designed to assist the recipient to eliminate or compensate for functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon amelioration of symptoms and more upon restoring functional capabilities. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment, focusing on maximum recovery and independence. It includes work readiness assessment, job development on behalf of the recipient, job matching, on the job training, and job support.

Psychosocial rehabilitation services may be provided in a facility, home, or community setting.

Admission Criteria

- See Common Admission Criteria
  - AND
- The member exhibits psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, prevocational, and educational functioning.

Continuing Stay Criteria

- See Common Continuing Stay Criteria

Discharge Criteria

- See Common Discharge Criteria

Clinical Best Practices
See Common Clinical Best Practices
Documentation includes at least a daily progress note that addresses each service provided.
A formal review of the treatment plan must be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur.

SPECIALIZED THERAPEUTIC FOSTER CARE

Specialized therapeutic foster care services are intensive treatment services provided to members under the age of 21 years with emotional disturbances who reside in state licensed foster homes. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention.

The goal of specialized therapeutic foster care is to enable a member to manage and work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting.

Specialized therapeutic foster care services incorporate clinical treatment services which are behavioral, psychological, and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster care parent(s), a primary clinician, and a psychiatrist. A specialized therapeutic foster parent must be available 24 hours per day to respond to crises or to provide special therapeutic interventions.

There are two levels of specialized therapeutic foster care, which are differentiated by the supervision and training of foster parents and intensity of programming required. Specialized therapeutic foster care levels are intended to support, promote competency, and enhance participation in normal, age-appropriate activities of members who present moderate to serious emotional or behavior management problems. Programming and interventions are tailored to the age and diagnosis of the members.

Specialized therapeutic foster care services are offered at Level I and Level II, with crisis intervention available at both levels.

Admission Criteria

See Common Admission Criteria
AND

Level I and Level II: General Requirements
  o The member is under age 21 and resides in a state licensed foster home.
  AND
  o The member has an emotional disturbance.
  AND
  o The member does not have a cognitive deficit severe enough to prohibit service from being of benefit to the member

Level I Requirements
  • The member has a history of abuse or neglect, or delinquent behavior and meets at least 1 of the following criteria:
    ▪ The member would require admission to a psychiatric hospital, a crisis stabilization unit, or a residential treatment center without specialized therapeutic foster care.
    ▪ The member has been admitted to a psychiatric hospital, a crisis stabilization unit, or a residential treatment center within the last 2 years.

Level II Requirements
  • The member meets the criteria for Level I.
  AND
  • The member exhibits at least 1 of the following behaviors:
    • Destruction of property;
    • Physical aggression toward people or animals;
    • Self-inflicted injuries;
    • Suicidal ideation or gestures;
    • An inability to perform activities of daily living and community living due to psychiatric symptoms.

Level I and II: Crisis Intervention Services
• The member meets the criteria for Level I or Level II.
  AND
• The member is experiencing a behavioral, emotional, or psychiatric crisis which requires stabilization.

Continuing Stay Criteria
• See Common Continuing Stay Criteria

Discharge Criteria
• See Common Discharge Criteria

Clinical Best Practices
• See Common Continuing Stay Criteria
• Prior to development of a treatment plan the provider completes a comprehensive behavioral health assessment of the member’s mental health status, substance use concerns, functional capacity, strengths and service needs, or an assessment is already on file and the assessment was conducted within the last 6 months.
  o A comprehensive behavioral health assessment must be initiated within 10 working days of crisis intervention services for any member who has not had a comprehensive behavioral health assessment in the past year.
• The comprehensive behavioral health assessment must include at least the following information:
  o General identifying information.
  o Reason for referral.
  o Sources of information (e.g., counselor, hospital, law enforcement).
  o Results of interviews and interventions conducted by the assessor;
  o Cognitive functioning, screening for emotional-social development, problem solving, communication, response of the child and family to the assessment, and ability to collaborate with the assessor.
  o Previous and current medications including psychotropic.
  o Last physical examination, including pre-natal, pregnancy and delivery history, and any known medical problems (e.g., prenatal exposure, accidents, injuries, hospitalizations) which may affect the recipient’s mental health status.
  o History of mental health treatment of the recipient’s parents and siblings. The mother’s history, including a depression screen, is important in developing this section.
  o History of substance use and alcohol or chemical dependency of the recipient’s family.
  o Legal involvement and status of the recipient and the recipient’s family.
  o Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
  o Emotional status, including a hands-on, interactive assessment of the recipient regarding sensory and regulatory functioning, attention, engagement, constitutional characteristics, and organization and integration of behavior.
  o Educational analysis, including daycare issues concerning behavioral and developmental concerns.
  o Functional analysis, including presenting strengths and problems of both the recipient and the recipient’s family.
  o Cultural analysis, including discovery of the family’s unique values, ideas, customs and skills that have been passed on to family members and that require consideration in planning and working with the recipient’s family. This component includes assessment of the family’s own operational style, including habits, characteristics, preferences, roles, and methods of communicating with each other.
  o Situational analysis including direct observation of the parent or caregiver’s interaction with the recipient in the home, school or child care setting, work site, and community, whenever the recipient routinely participates in these settings.
  o Present level of functioning, including social adjustment and daily living skills.
  o Activities catalog, including assessment of activities in which the recipient has interest or enjoys.
Ecological analysis, including relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family. A relational assessment should be provided to assess any attachment issues the recipient exhibits.

- Assessment of the desired services and goals from the recipient and the recipient’s parent or guardian’s viewpoint.
- An ICD diagnosis. If the recipient does not have a presenting ICD diagnosis, the provider must use the examination and observation diagnosis code.
- For recipients under the age of 4 years, Medicaid recommends use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-3) for assistance in determining the infant or child’s ICD diagnosis.
- For members age 6 through 20 years the comprehensive behavioral health assessment should also include completion of a standardized assessment tool, such as the Child & Adolescent Needs & Strengths An Information Integration Tool for Children and Adolescents with Mental Health Challenges CANS-MH Manual (CANS-MH) or the Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment Manual (CANS-Comprehensive).
- A treatment plan is developed by the primary clinician within the following number of days of admission:
  - Level I – 30 calendar days
  - Level II – 14 calendar days
  - Crisis Intervention – 14 calendar days
- The member’s parent or guardian should be included in the development of the individualized treatment plan, if the member is under the age of 18 years. Treatment planning for a member under the age of 18 years that does not include the member’s parent, guardian, or legal custodian in a situation of exception requires a documented explanation.
- A psychiatrist assigned to the program must interview the member and conduct a formal treatment plan review as follows from the date of authorization of the member’s initial treatment plan:
  - Level I – quarterly
  - Level II – monthly
  - Crisis Intervention – monthly
- The multidisciplinary team must re-authorize services no less than every 6 months.

**STATEWIDE INPATIENT PSYCHIATRIC PROGRAM**

**STATEWIDE INPATIENT PSYCHIATRIC PROGRAM (SIPP)** services are sub-acute medical and mental health-related services provided by or under the direction of professional or technical personnel, in an institution that is privately owned, licensed as a psychiatric hospital or residential treatment center for children and adolescents, and enrolled as a SIPP provider in the Florida Medicaid program.

SIPP serves high-risk Medicaid members under age 21 who require placement in a psychiatric residential setting due to a primary diagnosis of serious mental illness or emotional disturbance. Members served in SIPP typically require a level of service beyond that which is provided in community-based services or acute inpatient settings.

SIPP is intended to stabilize and adequately resolve presenting problems and symptoms, incorporate permanency, design effective aftercare treatment plans, and ensure coordination with State agencies and community services where applicable with the goals of reducing recidivism and relapse, and reducing the length and frequency of acute inpatient admissions.

**Admission Criteria**

- See Common Admission Criteria AND
• The member is under 21 years of age and is eligible under one of the following Medicaid categories:
  o TANF-related;
  o Supplemental Social Security (SSI);
  o SSI-related.
  AND
• If under State care and custody, the child has been assessed by a qualified evaluator, and the need for SIPP is indicated.
OR
• If in parental custody, the child has been assessed by a psychologist or psychiatrist, and the assessment has determined that the child has an emotional disturbance or a serious emotional disturbance.

Continuing Stay Criteria
• See Common Continuing Stay Criteria

Discharge Criteria
• See Common Discharge Criteria

Clinical Best Practices
• See Common Continuing Stay Criteria
• Prior to admission, the member's parent or guardian should receive an explanation of why SIPP is being recommended. The explanation should include the nature, purpose and expected length of treatment.
• The treatment plan should:
  o Be developed and implemented within 14 calendar days of admission.
  o Be based on the findings of the initial evaluation.
  o Be developed by a multidisciplinary team that includes the member’s parent, guardian or legal representative.
  o Prescribe an integrated program of therapies, activities, and experiences.
  o Provide for on-site educational services.
  o Reflect coordination with the member’s designated Child Welfare or Community Based Care counselor and permanency plan if the member is in state custody as well as with any assigned Targeted Case Manager during the last 120 calendar days of admission.
  o Be focused on allowing the member's safe return to the family and community services as soon as possible.
  o Include an initial formulation of the discharge plan.
• Treatment should be active, individualized, family-centered, culturally sensitive, trauma-informed, and focused on the problems that necessitated SIPP.
• The treatment plan is reviewed within 30 days of admission and monthly thereafter.
• The psychiatrist shall at a minimum:
  o Be on call 24 hours a day;
  o Interview the member weekly, or more often if medically necessary, to assess progress toward meeting treatment goals;
  o Supervise treatment for members who are on psychotropic medications;
  o Coordinate care with the member’s primary care physician when indicated by the member’s medical condition;
  o Attend member staffings.
• The provider shall at a minimum deliver:
  o 1 individual session and 1 family therapy session weekly, based on clinical best practices and accepted clinical guidelines, and provided in accordance with the member’s individual needs.
    • If the member is unable to participate in 60 minute individual and family therapy sessions, shorter and more frequent sessions should be offered to provide comparable intervention duration.
    • The member’s developmental and cognitive style may indicate the need for weekly individual sessions with a behavioral analyst in place of weekly individual therapy.
  o Weekly group therapy services.
therapeutic home assignments to allow the member and the member’s family to practice skills learned in the program.

- Assistance with helping the member and the member’s parent learn to manage behaviors in age appropriate ways.

- The behavioral analyst completes a behavioral review of any of the following:
  - Members ages 10 and under, upon admission.
  - Members who have an IQ of 69 or less, upon admission.
  - Members whose rate of time out is not decreasing in the timeframe anticipated by the treatment team.
    - As used here, time out does not include voluntary time outs that the member requests or initiates in the process of learning and practicing self-management of behavior.
  - Members whose behavior has required seclusion or restraint.

- The behavior review shall:
  - Identify behaviors contributing to the need for residential treatment so they may be addressed in the treatment plan.
  - Identify factors contributing to the need for time out, seclusion and restraint so early intervention measures can be taken.
  - Assess the seriousness of the member’s behavior and identify trends to determine if additional assessment or a behavior plan is necessary.
  - Ensure that the level or point system, if one is used, or other similar method is appropriate and understood by the member.

- The behavioral analyst completes a Comprehensive Behavior Analysis Assessment when any of the following occur:
  - A member has been restrained at least 2 times within a 30-day period.
  - A member has been in seclusion at least 3 times within a 30-day period.
  - A member is referred for assessment by the treatment team.

- The Comprehensive Behavior Analysis Assessment:
  - Describes the target behaviors.
  - Identifies the events, times and situations when the target behaviors occur.
  - Describes the antecedents and consequences controlling the target behaviors.
  - Describes the assessment methods.
  - Describes the direct observation of the member.
  - Displays the data collected in graphic form.
  - Summarizes the findings of the assessment and individualized recommendations.

- The behavioral analyst develops a behavior plan in consultation with the treatment team.

- The behavioral analyst trains and monitors staff to implement the interventions and collect data.

- Within 30 calendar days of the planned discharge, the primary therapist contacts the following to coordinate discharge:
  - The discharge setting;
  - The member’s school;
  - The receiving treatment provider;
  - The Regional Substance Abuse and Mental Health office;
  - Other agencies, programs, or community services from which the member will receive assistance.

- Within 1 week prior to discharge, the provider ensures that community supports and aftercare treatment services are in place.

### Targeted Case Management and Intensive Case Management

**Targeted Case Management (TCM)** assists member in gaining access to needed medical, social, educational, and other services.

The primary goal of Targeted Case Management is to optimize the functioning of members who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner.

Targeted Case Management services include working with the member and the member’s natural support system to develop and implement the member’s service plan. Services also include follow-up to determine the status of services, and the effectiveness of activities related to enhancing the member’s inclusion in the community.
**INTENSIVE CASE MANAGEMENT (ICM)** provides case management to adults who have a Serious and Persistent Mental Illness, and is intended to assist members with remaining in the community and avoiding institutional care.

Intensive Case Management case managers coordinate needs assessments, service planning, and provide service oversight. In addition, case managers also provide crisis support, and skills training in the member’s natural environment including training to promote independent living.

**Admission Criteria**

- **See Common Admission Criteria**
  AND
- **Additional TCM Admission Criteria for Children and Adolescents**
  - The member is 17 years of age or younger.
  - AND
  - The member has an emotional disturbance\(^{ii}\) or a serious emotional disturbance\(^{iii}\).
  - AND
  - The member is in out-of-home mental health placement or is at documented risk of out-of-home mental health placement.
  - AND
  - The member is not receiving duplicate case management services except in the following circumstances:
    - Optum Behavioral Health refers the member for 30-day certification and the area Medicaid office assigns a different case manager for the purpose of consultation, peer review, and provision of service planning.
    - The member’s regular case manager is unavailable.
    - The member is a transition youth age 18-22.
  - AND
- A member may receive TCM for up to 30 calendar days without meeting the above criteria under either of the following conditions:
  - The member has been referred by Optum Behavioral Health after a denied admission to or discharge from an inpatient psychiatric unit.
  - The member has been admitted to an inpatient psychiatric unit and has been identified as high risk by Optum Behavioral Health.
  - Coverage of TCM is not available beyond the 30-day period unless the member meets the criteria for TCM.
- **Additional TCM Admission Criteria for Adults**
  - The member is 18 years of age or older.
  - AND
  - The member has a Severe and Persistent Mental Illness\(^{iv}\) and, based upon professional judgment, the illness will last for at least 1 year.
  - AND
  - At least one of the following requirements are met:
    - The member is awaiting admission to or has been discharged from a state mental health treatment facility.
    - The member has been discharged from a mental health residential treatment facility.
    - The member has had more than 1 admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities in the past 12 months.
    - The member is at risk of institutionalization for mental health reasons.
    - The member is experiencing long-term or acute episodes of mental impairment that may put the member at risk of requiring more intensive services.
  - AND
  - The member is not receiving duplicate case management services.
  - If the member has relocated from a Department of Children and Families (DCF) district or region where he/she was receiving TCM, the member does not need to meet the above criteria.
  - A member may receive TCM for up to 30 calendar days without meeting the above criteria under either of the following conditions:
- The member has been referred by Optum Behavioral Health after a denied admission to or discharge from an inpatient psychiatric unit.
- The member has been admitted to an inpatient psychiatric unit and has been identified as high risk by Optum Behavioral Health.
- Coverage of TCM is not available beyond the 30-day period unless the member meets the criteria for TCM.
- Additional ICM Criteria for Adults
  - The member is 18 years of age or older.
  - The member meets at least one of the following requirements:
    - The member has resided in a state mental hospital for at least 6 months in the past 36 months.
    - The member has had 3 or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities in the past 12 months.
    - The member resides in the community and, due to a mental illness, exhibits behavior or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided.
    - If the member has relocated from a Department of Children and Families (DCF) district or region where he/she was receiving ICM, the member does not need to meet the above criteria.

Continuing Stay Criteria
- See Common Continuing Stay Criteria

Discharge Criteria
- See Common Discharge Criteria

Clinical Best Practices
- See Common Continuing Stay Criteria
- The case manager assesses each recipient of TCM/ICM as soon as possible commensurate with the member’s needs but no later than 30 calendar days from first receiving TCM/ICM.
- The assessment includes information provided by:
  - The member;
  - The referring person or agency;
  - The member’s family and friends (with consent);
  - The school district (for members under age 18 or who are still attending school);
  - Previous treating providers.
- The case manager makes at least 1 home visit prior to completion of the assessment. If a home visit is not possible, the case manager conducts a face-to-face interview with the member in another setting.
- The case manager creates an Individual Service Plan within 30 days of initiating ICM/TCM.
- Services and service frequency reflect the member’s, needs, goals, and abilities and must not simply reflect the Medicaid maximum allowable for this service (48, 15-minute units per day of ICM, 344 15-minute units per month of TCM).
- For members receiving ICM, the case management team is available 24 hours per day, 7 days per week.
- The case manager convenes case staffing at major decision points during the member’s involvement with the behavioral health system such as movements to a lesser or more restrictive environment in the community, or transfers to or from state hospitals.
  - Case staffing conferences are attended, as appropriate, by the member, family members, service providers and significant others.
- The case manager ensures that service plan goals and objectives are consistently pursued, and assesses progress toward the achievement of goals and objectives through monitoring activities such as telephone calls, home visits, case and treatment reviews, interviews and site visits.
  - When a member misses an appointment related to the service plan or is absent from a treatment program without notification, the case manager attempts to contact the member by
telephone or face-to-face meeting within 24 hours. If initial attempts to contact the client are unsuccessful, the case manager makes additional efforts by telephone, face-to-face meetings, or correspondence. Upon contacting the member, the case manager explores the reason for the absence or the missed appointment and works with the member to resolve issues inhibiting the implementation of the service plan.

- The service plan is reviewed and revised as significant changes occur in the member’s condition, situation, or circumstances, but no less frequently than every 6 months.
- The service plan review is a process conducted to ensure that services, goals, and objectives continue to be appropriate to the member’s needs and to assess the member’s progress and continued need for TCM/ICM. The member’s eligibility for TCM/ICM is re-evaluated during the service plan review.
- Evaluation and Service Planning: Additional Clinical Best Practices for Members in a Statewide Inpatient Psychiatric Program (SIPP)
  - TCM is available for children in a SIPP for the last 180 days prior to discharge.
  - For continuity, TCM is provided by the agency located in the same district as the member’s aftercare placement.
  - If a case manager is assigned prior to or at the time of placement, the case manager does the following:
    - Provides relevant information to SIPP staff regarding the member’s strengths as well as problems and symptoms that have resulted in the need for placement.
    - Informs the SIPP of previous mental health interventions and services, the member’s response to these services, and of significant individuals involved with the member.

- TCM services provided to the member include the following:
  - Meeting the member, parent or guardian, and contacting other people (guardian ad litem, child welfare, community-based care, and other agencies) to explain the role of the case manager for a member in a SIPP placement.
  - Attending at least 1 team meeting monthly and determine if treatment plan goals address the problems and symptoms that resulted in the need for the member’s restricted placement and the child’s strengths and assets. For children who are placed out of district, attendance may occur by phone.
  - Having face-to-face contact with the member and the member’s therapist monthly and contact with the family or guardian to support the family’s involvement in treatment and to further the treatment and discharge planning goals. If the case manager is unable to visit the member, the case manager must call the member at least once every 14 days.
  - Assisting the parent or guardian in coordinating aftercare services in the home, school, and community environments to assess and assist the member’s transition and adjustment to discharge placement.
  - Recommending and implementing any changes or revisions to the aftercare services array, as needed.
  - After discharge, collecting outcome data to include a two-month follow-up and reporting the information to the SIPP.

- TCM services for members in a SIPP are limited to 8 hours monthly. This limit may be increased to 12 hours monthly during the last month of the member’s SIPP placement to facilitate implementation of the aftercare plan.

- Evaluation and Service Planning: Additional Clinical Best Practices for Members in a State Mental Health Facility
  - ICM is available for members in a state mental health facility for the last 60 days prior to discharge.
  - The case manager carries out linkage and brokerage activities in the community prior to the member’s discharge in order to implement the service plan.
  - The case manager has face-to-face contact with the member within 2 business days of discharge.

**THERAPEUTIC BEHAVIORAL HEALTH ONSITE SERVICES**

**THERAPEUTIC BEHAVIORAL HEALTH ONSITE SERVICES** are intended to prevent members under the age of 21 years who have complex needs from requiring placement in a more intensive, restrictive behavioral health setting.
Services are coordinated through individualized treatment teams and include therapy services, behavior management, and therapeutic support.

Services are primarily provided 1:1 although group interventions may be used when justified.

Admission Criteria

- See Common Admission Criteria
  AND
- The member meets one of the following criteria:
  - The member is under the age of 2 years and meets one of the following criteria:
    - The member exhibits symptoms of an emotional or behavioral nature that are atypical for the member's age and development that interferes with social interaction and relationship development.
    OR
    - The member if failing to thrive due to emotional or psychosocial causes, not solely medical issues.
  - The member is ages 2 years through 5 years and meets both of the following criteria:
    - The member exhibits symptoms of an emotional or behavioral nature that are atypical for the member's age and development.
    AND
    - The member scores in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group.
  - The member is ages 6 years through 17 years and meets one of the following criteria:
    - The member has an emotional disturbance i.
    OR
    - The member has a serious emotional disturbance iii.
  - The member is ages 18 through 20 years, but otherwise meets the criteria for an emotional disturbance or serious emotional disturbance.

Continuing Stay Criteria

- See Common Continuing Stay Criteria

Discharge Criteria

- See Common Discharge Criteria

Clinical Best Practices

- See Common Continuing Stay Criteria
- Prior to the development of a treatment plan the provider completes and provides to the member/member's parent or guardian an assessment of the member's mental status, substance use concerns, functional capacity, strengths, and service needs or must have an assessment on file that has been conducted in the last 6 months.
  - For members under the age of 6 years, a comprehensive behavioral health assessment completed within the last year satisfies the current assessment requirement.
- The treatment plan contains:
  - A list of services:
    - Therapy services include individual and family therapy, as well as collaborative development of the formal discharge plan;
    - Behavior management services include monitoring on interactions intended to improve behavior and the member and family’s skill deficits and assets, development of a behavior plan and integration of the plan into the member’s overall treatment plan, training the member’s family and others in implementing the behavior plan, monitoring interactions between the member and the member’s family and others to measure progress, and coordinating services;
    - Therapeutic support services include 1:1 supervision and intervention with the member during therapeutic activities, skills training, and assistance to the member and the member’s family and others implementing the member’s behavior plan;
- The amount, frequency, and duration of each service for the 6 month duration of the treatment plan. It is not permissible to use terms “as needed”, “p.r.n.”, or to state that the member will receive a service “x to y times per week”;
- Dated signature of the member/member’s parent or guardian;
- If the member’s age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided in the treatment plan;
- Signature of the treatment team members who participated in development of the plan;
- A signed and dated statement by the treating provider that services are medically necessary and appropriate to the member’s diagnosis and needs; and
- Discharge criteria.

- Providers delivering services to members under the age of 6 years must have training and experience in infant, toddler, and early child development as well as methods for observing and assessing young children.
- The provider in conjunction with the individualized treatment team and, whenever possible, the member/member’s parent or guardian conducts a formal review of the treatment plan at least every 6 months. The treatment plan is reviewed more often than once every 6 months when significant changes occur.
- The treatment plan review is a process conducted by the treatment team to ensure that treatment goals, objectives, and services continue to be appropriate to the member’s needs and to assess the member’s progress and continued need for services.
- The treatment plan review contains all of the following components:
  - Current diagnoses and justification for any changes;
  - The member’s progress toward meeting individualized goals and objectives;
  - The member’s progress toward meeting individualized discharge criteria;
  - Updates to the aftercare plan;
  - Findings;
  - Recommendations;
  - Dated signature of the member/member’s parent or guardian;
  - Signatures of the treatment team members who participated in the review of the plan;
  - A signed and dated statement by the treating provider that services are medically necessary and appropriate to the member’s diagnosis and needs.
- The updated treatment plan and progress notes reflect how services are coordinated with services delivered to the member by other providers
- If the treatment plan review indicates that goals and objectives have not been met, documentation must reflect the treatment team’s reassessment of services and justification if no changes are made.
- The provider and the member/member’s parent or guardian develops an initial discharge plan within 45 calendar days of admission to Therapeutic Behavioral On-Site Services. The discharge plan includes measurable criteria that will be used to identify the member’s readiness to transition to a new level of care or out of care. The discharge plan also includes community resources, activities, services, and supports that will be utilized to help the member sustain gains achieved during Therapeutic Behavioral On-Site Services.

**THERAPEUTIC GROUP CARE SERVICES**

**THERAPEUTIC GROUP CARE SERVICES** are community-based, psychiatric residential treatment services designed for recipients under the age of 21 years with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 recipients under the age of 21 years.

Therapeutic group care services are intended to support, promote, and enhance competency and participation in normal age-appropriate activities of recipients who present moderate to severe psychiatric, emotional, or behavior management problems related to a psychiatric diagnosis. Programming and interventions are highly individualized and tailored to the age and diagnosis of the recipient. Therapeutic group care is intended to provide a high degree of structure, support, supervision, and clinical intervention in a home-like setting.
These services are appropriate for members who are ready to transition from a more restrictive treatment program or for those who require more intensive community-based treatment to avoid placement in a more restrictive treatment setting.

Generally, these services include psychiatric and therapy services, therapeutic supervision, and the teaching of problem solving skills, behavior strategies, normalization activities, and other treatment modalities, as authorized in the treatment plan.

**Admission Criteria**
- See Common Admission Criteria

**Continuing Stay Criteria**
- See Common Continuing Stay Criteria

**Discharge Criteria**
- See Common Discharge Criteria

**Clinical Best Practices**
- See Common Continuing Stay Criteria
- The treatment plan must be completed within 14 days of admission and a psychiatrist must interview the member and conduct a formal treatment plan review monthly or when significant changes occur.
- If the treatment plan contains an individualized behavior management component, the behavior analyst must review and sign the component. The behavior management plan must be consistent with treatment outcomes and objectives.
- If a parent or guardian, team member or school personnel are not at a treatment plan meeting, the record must reflect that a staff person contacted them for their input.
- The psychiatrist must interview each member monthly to assess progress toward meeting treatment goals, or more often if medically necessary.

**REFERENCES**


*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines and in the related Behavioral Clinical Policy

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<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>05/09/2018</td>
<td>• Combined previously separate LOCGs into one document</td>
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1. Per F.S. 394.492 and as defined in the Agency for Health Care Administration’s Specialized Therapeutic Services Coverage and Limitations Handbook, “emotional disturbance” is defined as a person under the age of 21 years who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation.

2. Per F.S. 394.492 an emotional disturbance is present when a child is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation. The term does not include a child or adolescent who meets the criteria for involuntary placement.

3. Per F.S. 394.492 a serious emotional disturbance is present when a child diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; and exhibits behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation.

4. According to Federal Register 58, Number 96, the federal definition of Serious Mental Illness (SMI) includes persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental, dementias, mental disorders due to a medical condition and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.