



United Behavioral Health

Supplemental Clinical Criteria: Florida Medicaid

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INTRODUCTION AND INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*¹ 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 OptumHealth Behavioral Solutions of California ("Optum-CA")).

Other *Clinical Criteria*² may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®³. 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. 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.

¹ **Clinical Criteria (State or Contract Specific):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

² **Clinical Criteria**

(ASAM Criteria) Criteria used to make medical necessity determinations for substance-related disorder benefits.

(Level of Care Utilization System-LOCUS) Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions for adults ages 19 and older.

(Child and Adolescent Service Intensity Instrument-CASII)-Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.

(Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children ages 0-5.

³ Optum is a brand used by United Behavioral Health and its affiliates.

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

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."

EVIDENCE-BASED PRACTICE CRITERIA

In addition to the applicable Clinical Criteria, for all services, treatments and levels of care, services are delivered according to evidence-based practices consistent with the applicable definition of Medical Necessity and the following:

- Services are:
 - Provided under an individualized plan of treatment or diagnostic plan developed in conjunction with providers of appropriate disciplines on the basis of a thorough evaluation of the member's strengths and disabilities;
 - Supervised and evaluated by the most appropriate physician or provider;
 - For the purpose of diagnosis or services are reasonably expected to improve the member's condition:
 - It is not necessary that a course of therapy have as its goal restoration of the member to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some members. For many other members, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement.
 - "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the member's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
- The individualized written plan includes the type, amount frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals.
- For continued service, the member continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice.
- Discharge is indicated when stability can be maintained without further treatment or with less intensive treatment.
 - Discharge planning includes linkages with community resources, supports, and providers in order to promote a member's return to a higher level of functioning in the least restrictive environment.

A discharge plan and a summary with recommendations for appropriate services concerning follow-up or aftercare have been developed as well as a summary of the member's condition upon discharge.

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

- The member has a mental health diagnosis; and
- The member is at least 16 years of age; and
- Services are provided by one of the following qualified professionals: Physician, Psychiatrist, PPA, Psychiatric ARNP, LPHA, Master's level CAP, Master's level practitioner, CAP, Bachelor's level practitioner, Certified recovery peer specialist, Certified psychiatric rehabilitation practitioner, Certified recovery support specialist, or Certified behavior health technician; and
- Services are provided in a group with a maximum staff to member ratio of 1 to 12; 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.

Service Delivery

- 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

- Services must be provided by one of the following qualified professionals: Physician, Psychiatrist, PPA, Psychiatric ARNP, LPHA, Master's level CAP, Master's level practitioner, CAP, Bachelor's level practitioner, Certified recovery peer specialist, Certified psychiatric rehabilitation practitioner, Certified recovery support specialist, Certified behavior health technician, or Substance abuse technician; and
- Services are provided in a group with a maximum staff to member ratio of 1 to 12; 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.

Service Delivery

- 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

Level I and Level II: General Requirements

- The member is under age 21 and resides in a state licensed foster home; and
- The member has an emotional disturbanceⁱ; and
- 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.

Service Delivery

- 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.
- 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:
 - General identifying information.

- Reason for referral.
- Sources of information (e.g., counselor, hospital, law enforcement).
- Results of interviews and interventions conducted by the assessor.
- 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.
- Previous and current medications including psychotropic.
- 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.
- 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.
- History of substance use and alcohol or chemical dependency of the recipient's family.
- Legal involvement and status of the recipient and the recipient's family.
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
- 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.
- Educational analysis, including daycare issues concerning behavioral and developmental concerns.
- Functional analysis, including presenting strengths and problems of both the recipient and the recipient's family.
- 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.
- 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.
- Present level of functioning, including social adjustment and daily living skills.
- 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 member under age 6 the comprehensive behavioral health assessment should also include completion of a standardized assessment, such as the Child & Adolescent Needs and Strengths An Information Integration Tool for Early Development CANS-0 to 3 Manual (CANS 0-3) and the Florida's Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment 0-5 Manual (CANS 0-5).
- 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 And 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 illnessⁱⁱ 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

- The member is under 21 years of age and is eligible under one of the following Medicaid categories:
 - TANF-related;
 - Supplemental Social Security (SSI);
 - 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^{iiiiv}.

Service Delivery

- 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:
 - Be developed and implemented within 14 calendar days of admission.
 - Be based on the findings of the initial evaluation.
 - Be developed by a multidisciplinary team that includes the member's parent, guardian or legal representative.
 - Prescribe an integrated program of therapies, activities, and experiences.
 - Provide for on-site educational services.
 - 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.
 - Be focused on allowing the member's safe return to the family and community services as soon as possible.
 - 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:
 - Be on call 24 hours a day;
 - Interview the member weekly, or more often if medically necessary, to assess progress toward meeting treatment goals;
 - Supervise treatment for members who are on psychotropic medications;
 - Coordinate care with the member's primary care physician when indicated by the member's medical condition;
 - Attend member staffings.
- The provider shall at a minimum deliver:
 - 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.
 - 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

TCM Admission Criteria for Children and Adolescents

- The member is 17 years of age or younger; and
- The member has an emotional disturbance or a serious emotional disturbance; 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 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; and
- 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.

Service Delivery

- 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

- 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 is 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; or
 - The member has a serious emotional disturbance.
- The member is ages 18 through 20 years, but otherwise meets the criteria for an emotional disturbance or serious emotional disturbance.

Service Delivery

- 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.

Service Delivery

- 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

State of Florida, Administrative Code (2014). Rule 59G-4.050 Community Behavioral Health Services.

State of Florida, Administrative Code (2017). Rule 59G-4.295. Specialized Therapeutic Services.

State of Florida, Administrative Code. (2015). Rule 59G-4.120. Statewide Inpatient Psychiatric Program.

State of Florida, Administrative Code. (2017). Rule 59G-1.010 (166), Definitions.

State of Florida, Administrative Code. (2008). Rule 59G-4.199 Mental Health Targeted Case Management Services.

State of Florida, Administrative Code. (2008). 65E-9.008, Mental Health Program, Licensure of Residential Treatment Centers, Admission.

State of Florida, Administrative Code. (2008). 65E-9.009, Mental Health Program, Licensure of Residential Treatment Centers, Treatment Planning.

State of Florida, Administrative Code. (2008). 65E-9.010, Mental Health Program, Licensure of Residential Treatment Centers, Length of Stay.

State of Florida, Administrative Code. (2008). 65E-9.011, Mental Health Program, Licensure of Residential Treatment Centers, Discharge and Discharge Planning.

State of Florida, Administrative Code. (2016). Rule 65C 30.007

REVISION HISTORY

Date	Action/Description
05/09/2018	• Version 1
01/31/2019	• Version 2

ⁱ 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.

ⁱⁱ 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.

ⁱⁱⁱ 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.

^{iv} 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.