INTRODUCTION

The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing\(^1\) for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)).

The Level of Care Guidelines is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS’ National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The Level of Care Guidelines is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.

For more information on guiding principles for the Level of Care Guidelines and their development, approval, dissemination, and use, please see the Introduction to the Level of Care Guidelines, available at: www.providerexpress.com > Clinical Resources > Level of Care Guidelines.

Before using this guideline, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.

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.

\(^1\) The terms “recovery” and resiliency” are used throughout the Psychological and Neuropsychological Testing Guidelines. SAMHSA defines “recovery” as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines “resilience” as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines “recovery” as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.
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.

1. Admission Criteria
   - see "Common Criteria and Best Practices for All Levels of Care":
     AND
   - see "Admission Criteria" in the Level of Care Guideline, Psychosocial Rehabilitation:
     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.
     AND
   - Services are medically necessary.

2. Continued Service Criteria
   - see "Common Criteria and Best Practices for All Levels of Care":

3. Discharge Criteria
   - see "Common Criteria and Best Practices for All Levels of Care":

4. Clinical Best Practices
   - see "Common Criteria and Best Practices for All Levels of Care":
   - see "Clinical Best Practices" in the Level of Care Guideline, Psychosocial Rehabilitation:
   - 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.

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

HISTORY/REVISION INFORMATION

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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.”