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 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.

TARGETED CASE MANAGEMENT AND INTENSIVE CASE MANAGEMENT

TARGETED CASE MANAGEMENT (TCM) assists member in gaining access to needed medical, social, educational, and other services.

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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.
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.

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

**Additional 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.
• 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:
  o The member has been referred by Optum Behavioral Health after a denied admission to or discharge from an inpatient psychiatric unit.
  o 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:
  o The member has resided in a state mental hospital for at least 6 months in the past 36 months.
  o 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.
  o 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.

2. Continued Service Criteria
• see “Common Criteria and Best Practices for All Levels of Care”: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

3. Discharge Criteria
• see "Common Criteria and Best Practices for All Levels of Care": https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

4. Clinical Best Practices
• see "Common Criteria and Best Practices for All Levels of Care": https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html
• see "Clinical Best Practices" in the Level of Care Guideline, Case Management: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html
• 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:
  o The member;
  o The referring person or agency;
  o The member’s family and friends (with consent);
  o The school district (for members under age 18 or who are still attending school);
  o 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.
  o 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.
  o 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:
  o 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.
  o 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:
  o 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.
  o 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.
  o 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.
  o 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.
  o Recommending and implementing any changes or revisions to the aftercare services array, as needed.
  o 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.

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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i 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.”

ii 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.

iii 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.

iv 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.