United Behavioral Health

Level of Care Guidelines: Iowa Medicaid United Healthcare Plan of the River Valley, Inc.

Document Number: BH803IA062018 **Effective Date**: June 13, 2018

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INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans 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")).

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®[1]. 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. 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 guideline and the member's specific benefit, the member's specific benefit supersedes 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.
    - 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.

  AND
- 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 require the intensity and scope of services provided in the proposed level of care.
  AND
- Co-occurring behavioral health and medical conditions can be safely managed in the proposed level of care.
  AND
- Services are medically necessary.

[1] Optum is a brand used by United Behavioral Health and its affiliates.

AND

- For all levels of care, services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of funcitioning.
    - It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patient. For many other psychiatric patients, 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 were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
    - In addition to the above, for outpatient services, some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, coverage depends on whether the criteria discussed above are met; for example, that stability can be maintained without further treatment or with less intensive treatment.

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.

  AND
- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.

  AND
- Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.

  AND
- The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated 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 form 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.

TRANSITION PLANNING

Transition planning is initiated with the member as soon as clinically appropriate in the person-centered planning and service delivery process, ideally at the onset of treatment in order to prepare the member, the provider and the community as needed. Transition planning may be included as part of the person-centered plan and may be combined with the discharge plan/summary as long as it is made clear which components of the plan are relevant to transition planning, discharge planning or termination of services.

The transition plan:

- Is prepared or updated to ensure a seamless transition when a member:
    - Is transferred to another level of care or program.
    - Prepares for a planned discharge.
- Identifies the member's current:
    - Progress is his/her own recovery or move toward wellbeing.
    - Gains achieved during program participation.

- Identifies the member's need for support systems or other types of services that will assist in continuing his or her recovery, wellbeing, or community integration.
- Includes information on the continuity of the member's medications when applicable.
- Includes referral information, such as contact name, telephone number, locations, hours, and days of services when applicable.
- Includes communication of information on options and resources available if symptoms recur or additional services are needed when applicable.
- Includes:
    - Strengths.
    - Needs.
    - Abilities.
    - Preferences.
- Is developed with the input and participation of:
    - The member.
    - The family/legal guardian, when applicable and permitted.
    - A legally authorized representative, when appropriate.
    - Team members.
    - The referral source when appropriate and permitted.
- Is given to individuals who participate in the development of the transition plan when permitted.

MENTAL HEALTH: CRISIS SERVICES

Crisis Response Services is an array of services provided to individuals experiencing a mental health crisis aimed at assessment and intervention to stabilize the member's level of functioning. A mental health crisis is defined as a "behavioral, emotional, or psychiatric situation which results in a high level of stress or anxiety for the individual or persons providing care for the individual and which cannot be resolved without intervention." (441-Ch. 24.20)

Crisis stabilization community based services are short-term services designed to de-escalate a crisis situation and stabilize an individual experiencing a mental health crisis, provided where the individual lives, works or recreates. (441-24.20)

1. Admission criteria for crisis stabilization community-based services:
    - The member is presenting active symptomology consistent with a mental health crisis
      AND
    - The mental health crisis is interfering with the member's activities of daily living
      AND
    - The factors leading to admission and/or the member's history of treatment suggest that the symptoms can be stabilized with crisis stabilization services within the community
      AND
    - The member does not require inpatient hospitalization but requires crisis stabilization services that may include medication, counseling, referral, peer support and linkage to ongoing services, not expected to exceed 5 days

2. Continued stay criteria for crisis stabilization community-based services:
    - The individual's condition continues to meet admission criteria for crisis stabilization.
      AND
    - The individual's treatment does not require a more intensive level of care, and a less intensive level of care would not be sufficient to meet individual's needs.
      AND
    - There is a written stabilization plan that identifies the short-term strategy to stabilize the crisis developed by the provider in collaboration with crisis staff and the member.
      AND
    - This is evidence the stabilization plan has been activated with interventions that are appropriate to stabilize the member's crisis
    - There is documented evidence of active discharge planning.

Crisis stabilization residential services is a short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual experiencing a mental health crisis, and is provided in an organization-arranged settings of no more than 16 beds. (441-24.20)

1. Admission criteria for crisis stabilization residential services:
   - Meets all criteria for crisis stabilization community based admission criteria
     AND
   - Stabilization of the member's mental health crisis can be better addressed in an organization-arranged crisis stabilization setting, rather than the member's home

2. Continued stay criteria for crisis stabilization residential services:
   - Meets all criteria for crisis stabilization community based continued stay criteria
     AND
   - Stabilization of the member's mental health crisis can be better addressed in an organization-arranged crisis stabilization setting, rather than the member's home

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Mobile response services are services provided on-site, face-to-face mental health crisis services for an individual experiencing a mental health crisis. Mobile response staff have the capacity to intervene wherever the crisis is occurring, including but not limited to the individual's place of residence, an emergency room, police station, outpatient mental health setting, school, recovery center or any other location where the individual lives, works, attends school or socializes.

1. Admission criteria for mobile response services:
   - The member is presenting active symptomology consistent with a mental health crisis
     AND
   - The mental health crisis is interfering with the member's activities of daily living
     AND
   - The factors leading to admission and/or the member's history of treatment suggest that the symptoms can be stabilized with crisis stabilization services within the community
     AND
   - A crisis screening indicates that mobile response service is appropriate to be provided where the crisis is occurring.

MENTAL HEALTH: APPLIED BEHAVIOR ANALYSIS

Intensive Behavior Therapy (IBT) is an umbrella term for a variety of outpatient behavioral/educational interventions that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with ASDs. The most common IBT is Applied Behavior Analysis (ABA).

Applied behavioral analysis is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

The course of IBT is focused on addressing the factors that precipitated admission to the point that the factors that precipitated admission no longer require treatment.

- Admission Criteria
  - The member is 20 years old or younger and ABA is medically necessary[i].
    AND
  - The member has been assigned a diagnosis of Autism based on a diagnostic assessment dated 24 months or less from admission by a developmental pediatrician, child psychiatrist or clinical psychologist.
    AND
  - ABA services will be provided by a board certified Behavior Analyst (BCBA) or a health professional permissible under state law.
    AND
  - The family is engaged and willing to participate in the member's ABA treatment.
    AND
  - There are acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors and the member's current condition can be safely, efficiently, and effectively assessed and/or treatment in this setting. Examples include:
    - Reducing problem behavior such as aggression or self-injury;

- Increasing socially appropriate behavior such as reciprocity;
- The acquisition of communication, self-help and social skills;
- Learning to tolerate changes in the environment and activities.

AND

- The member is not in imminent or current risk of harm to self, others, and/or property.

MENTAL HEALTH: DAY TREATMENT

Day Treatment provides a combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive interactions between the provider and the member, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities for a period of three to five hours per day, three or four times per week in a licensed Community Mental Health Center.

Day Treatment services are typically provided to members 21 years and older with more severe mental health conditions and related functional impairments. Day treatment services for adults are structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

The course of treatment in Day Treatment is focused on addressing the factors that precipitated admission to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria
   - The member has a Serious Mental Illness (SMI) [ii]

     AND
   - The member is not in imminent or current risk of harm to self, others, and/or property.

     AND
   - Assessment and diagnosis and/or treatment planning requires observation and interaction for at least three to five hours per day, three or four times per week in a licensed Community Mental Health Center. Examples include:
     - Assessment requires frequent interaction with the member, and observation of the member with others.
     - The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.

     OR
   - The member requires engagement and support which requires extended interaction between the member and the program. Examples include:
     - The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center.
     - The member has been unable to access or utilize the member's family or other natural resources on their own.

     OR
   - The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
     - Maintain their current living situation;
     - Return to work or school.

     OR
   - The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include the following:
     - Assistance with developing the skills needed to self-manage medications;
     - Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.
     - Criteria for Overnight Housing Coupled with a Day Treatment Program
     - Overnight housing is covered by the benefit plan.

     AND
   - The treatment setting is separate from the housing.

     AND
   - An unsupportive or high-risk living situation is undermining the member's recovery.

OR

- Routine attendance at Day Treatment is hindered by the lack of transportation.

MENTAL HEALTH: ELECTROCONVULSIVE THERAPY

Electroconvulsive therapy (ECT) is a treatment technique typically administered by a psychiatrist privileged to perform ECT and an anesthesiologist delivered in inpatient or outpatient settings that provokes a therapeutic response by applying an electrical current to the brain to induce a controlled seizure. The course of Electroconvulsive Therapy is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the factors that precipitated admission no longer require treatment.

ECT may be provided on an outpatient basis or during an inpatient stay.

The initial, acute phase of ECT (aka, the index course) may be followed by continuation and maintenance phases of treatment when clinically indicated.

1. Admission Criteria
    - The member is diagnosed with any of the following conditions:
        - Major Depressive Disorder;
        - Bipolar Disorder;
        - Schizophrenia Spectrum and Other Psychotic Disorders.

MENTAL HEALTH: HOME HEALTH

HOME HEALTH Assessment and diagnostic services, and active behavioral health treatment provided in the member's home where the factors that precipitated the need for service are assessed and stabilized to the point that the member's condition can be safely, efficiently and effectively treated in an ambulatory setting, or it is determined that treatment is no longer required.

Home-based assessment and treatment are separate services, and the findings of a home-based assessment may or may not support the need for home-based treatment.

1. Admission Criteria
    - The member is not in imminent or current risk of harm to self, others, and/or property.
      AND
    - Acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors have occurred, and the member's current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.
      AND
    - The member is homebound. A member is homebound when:
        - A physical condition restricts the member's ability to leave his/her residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
        - A behavioral health condition is manifested in part by an inability to leave home, or is such that it would not be considered safe for the member to leave home unattended.
2. Criteria for Home-Based Assessment
    - An evaluation of the acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors is required to determine if behavioral health services are needed.
      OR
    - An evaluation of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.
3. Criteria for Home-Based Treatment
    - The member's signs and symptoms are primarily or exclusively experienced at home.
      OR
    - The factors leading to admission undermine the member's participation in treatment at an ambulatory setting.

MENTAL HEALTH: IN HOME FAMILY THERAPY

Children's Mental Health Waiver

In-home family therapy services are skilled therapeutic services provided to the child and family. Services will increase the child and family's ability to cope with the effects of the child's serious emotional disturbances on the family relationships.

The goal of in-home family therapy is to maintain a cohesive family unit. The service must support the family in developing coping strategies that will enable the child to continue living within the family environment.

In-home family therapy is exclusive and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through other funding sources.

1. Admission Criteria
   - The member is enrolled in the Children's Mental Health Waiver.
     AND
   - The member is not at imminent risk of harm to self or others.
     AND
   - If co-occurring mental health and substance use disorders or co-morbid medical conditions are present, they can be safely managed.
     AND
   - There has been an escalation of symptoms that cannot be managed in the member's living environment without in-home therapeutic intervention in the member's place of residence with the family/caregiver.
     AND
   - The member resides in stable housing and agrees along with the member's family/caregiver, to receive in-home therapeutic services in the member's residence with the family/caregiver.
2. Continued Service Criteria
   - The provider has evaluated the member and caregiver's needs upon admission.
     AND
   - The services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

MENTAL HEALTH: INPATIENT SERVICES

A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Inpatient Admission Criteria

- The factors leading to admission, and /or the member's history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include the following:
  - A life-threatening suicide attempt;
  - Self-mutilation, injury, or violence towards others or property;
  - Treat of serious harm to self or others;
  - Command hallucinations directing harm to self or others.

  OR
- The factors leading to admission suggest that the member's condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:
  - A physical cause for the member's signs and symptoms cannot be ruled out in a less intensive setting.

- A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.

OR

- The factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include:
  - Acute impairment of behavior or cognition that interferes with activities of daily living (ADLs) to the extent that the welfare of the member or others is endangered.
  - Psychosocial and environmental problems that threaten the member's safety or undermines engagement in a less intensive level of care.

OR

- The factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

2. Inpatient Continued Service Criteria

- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
  - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating);
  - Health-related services provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;
  - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. Inpatient Clinical Best Practices

- The psychiatrist, in conjunction with the treatment team, completes the intial evaluation commensurate within 24 hours of admission.
- During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.
- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

MENTAL HEALTH: INTENSIVE OUTPATIENT PROGRAM

A structured program that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life.

The course of treatment in an Intensive Outpatient Program is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

An Intensive Outpatient Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Intensive Outpatient Program services that are coupled with overnight housing.

1. Intensive-Outpatient Program (IOP) Admission Criteria

- The member is not in imminent or current risk of harm to self, others, and/or property.

AND

- Assessment and diagnosis and/or treatment planning requires observation and interaction a minimum of 9 hours per week for adults and 6 hours per week for children/adolescents. Examples include the following:

- Assessment requires frequent interaction with the member and observation of the member with others.
- The treatment plan must be frequently changed, which requires that the provider have face-to-face interactions with the member several times a week.

OR

- The member requires engagement and support which requires extended interaction between the member and the program. Examples include:
  - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.
  - The member has been unable to access or utilize the member's family or other natural resources on his or her own.

OR

- The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
  - Maintain their current living situation;
  - Return to work or school.

OR

- The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of skills include those that help the member:
  - Assistance with developing the skills needed to self-manage medications;
  - Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

2. Criteria for Overnight Housing Coupled with an Intensive Outpatient Program
   - Overnight housing is covered by the benefit plan.
     AND
   - The treatment setting is separate from the housing.
     AND
   - Either of the following apply:
     - An unsupportive or high-risk living situation is undermining the member's recovery;
     - Routine attendance at the intensive outpatient program is hindered by a lack of transportation.

3. Intensive-Outpatient Program (IOP) Clinical Best Practices

- The responsible provider and the treatment team complete the initial evaluation commensurate with the member's needs, no later than three (3) treatment days after admission.
- During admission, a psychiatrist is available to consult with the program during and after normal program hours.

MENTAL HEALTH: INTENSIVE PSYCHIATRIC REHABILITATION TREATMENT

Intensive Psychiatric Rehabilitation Treatment services are designed to increase the skills and functioning of members with psychiatric disabilities so that they are able to develop successful living, working, learning and social roles in the member's chosen community environment(s). IPRT promotes recovery, full community integration, and improved quality of life by providing services that are collaborative, person directed, individualized, and evidence-based[iii].

IPRT services are provided both at a program site and in off-site community settings and may include:

- Psychiatric rehabilitation readiness determination – Helps to assess the member's readiness based on the member's perceived needs, motivation, and awareness of the process involved in making change in his or her life.
- Psychiatric rehabilitation goal setting – Assists the member in selecting a specific environment in which he/she intends to live, work, learn, and/or socialize.
- Psychiatric rehabilitation functional and resource assessment – Assists the member in understanding his or her skills and deficits, and the social and environmental resources that may help the member achieve psychiatric rehabilitation goals.

- Psychiatric rehabilitation skills and resource development – Assists the member improve his or her use of skills and the adaptation of social and environmental resources to achieve psychiatric rehabilitation goals.
- Psychiatric rehabilitation support services – Enhances the capacity of collaterals to serve as a resource in assisting the member to achieve or maintain his or her psychiatric rehabilitation goals.

1. Admission Criteria
    - The member is 21 years of age or older;
      AND
    - The member has been diagnosed with a mental health condition that seriously impairs his or her ability to function in two or more of the following areas:
        - Housing (accessing or maintaining),
        - Employment/education,
        - Financial management,
        - Ability to obtain needed support services,
        - Social relationships/supports,
        - Basic living skills,
        - Health/medical management

      AND
    - The member is not in imminent or current risk of harm to self or others and/or property;
      AND
    - Co-occurring behavioral health or physical conditions can be safely managed.

MENTAL HEALTH: OUTPATIENT SERVICES

Assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting or in the member's home. The course of treatment in Outpatient is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the factors that precipitated admission no longer require treatment. Individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes.

Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting 60 minutes or longer (53+ minutes, per the CPT Time Rule). Extended outpatient sessions may require prior authorization before services are received, except in extenuating circumstances, such as a crisis. Please check the member's specific plan document.

Home-based assessment and treatment are separate services, and the findings of a home-based assessment may or may not support the need for home-based treatment.

1. Outpatient Admission Criteria
    - The member is not in imminent or current risk of harm to self, others, and/or property.
      AND
    - The member's current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

2. Coverage for extended outpatient sessions lasting longer than 60 minutes (53+ minutes, per the CPT Time Rule) may be indicated in the following non-routine circumstances:
    - The member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and an extended outpatient session is appropriate for providing rapid and time-limited assessment and stabilization.
        - Consider extending coverage for acute crisis situations in 30-minute increments when clinically indicated.
        - Prior authorization is not required when there is an acute crisis.
    - An individual psychotherapy session with evaluation and management is being provided, and there is an unexpected complication resulting from pharmacotherapy, or an acute worsening of the member's condition that would likely require a more intensive level of care if the outpatient session is not extended.

- Periodic involvement of children, adolescent, or geriatric members' family in a psychotherapy sessions when such involvement is essential to the member's progress (e.g., when psychoeducation or parent management skills are provided).
    - This is not synonymous with marital or family therapy.
- An extended session is otherwise needed to address new symptoms of the reemergence of old symptoms with a rapid, time-limited assessment and stabilization response. Without an extended outpatient session, the new-re-emerging symptoms are likely to worsen and require a more intensive level of care.

3. Extended outpatient sessions may be covered in the following circumstances, as indicated by the member's condition and specific treatment needs:
    - The member has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder, Obsessive Compulsive Disorder, or Specific Phobia, and is being treated with Prolonged Exposure Therapy.
    - The member is being treated with Eye Movement Desensitization and Reprocessing (EMDR) or Traumatic Incident Reduction (TIR) for Posttraumatic Stress Disorder (PTSD).
    - The member's Borderline Personality Disorder diagnosis is a covered condition, and the member is being treated with Dialectical Behavior Therapy (DBT).

4. Home-Based outpatient assessment and/or treatment may be covered when the member is homebound. A member is homebound when:
    - A physical condition restricts the member's ability to leave his/her residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
    - A behavioral health condition is manifested in part by an inability to leave home, or is such that it would not be considered safe for the member to leave home unattended.

5. Home-based outpatient assessment may be covered when:
    - An assessment of the acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors is required to determine if behavioral health services are needed.
    - An assessment of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.

6. Home-based outpatient treatment may be covered when:
    - The member's signs and symptoms are primarily or exclusively experienced at home.
    - The factors leading to the admission undermine the member's participation in treatment at an ambulatory setting.

7. Outpatient Clinical Best Practices
    - The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member's recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member's functional status improves, the frequency of visits decreases to meet the member's current needs and treatment goals. Factors that may impact frequency and duration include the following:
        - The goals of treatment;
        - The member's preferences;
        - Evidence from clinical best practices which supports frequency and duration;
        - The need to monitor and manage imminent risk of harm to self, others, and/or property.
    - The provider informs the member of the process to be followed in the event of an after-hours emergency, such as the availability of on-call services. The process is not solely reliant on the Emergency Room.
    - The following conditions may support home-based assessment and/or treatment:
        - Agoraphobia or Panic Disorder;

- Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairments of thoughts/cognition grossly affect the member's judgment and decision making, and therefore the member's safety;
- Acute depression with severe vegetative symptoms;
- Behavioral health problems associated with medical problems that render the member homebound.

MENTAL HEALTH: PARTIAL HOSPITALIZATION

A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life.

A Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that coupled with overnight housing.

1. Admission Criteria
   - Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include the following:
     - Assessment requires frequent interaction with the member, and observation of the member with others.
     - The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.

     OR
   - The member requires engagement and support which requires extended interaction between the member and the program. Examples include the following:
     - The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center, such as engagement with wraparound services or natural resources.
     - The member has been unable to access or utilize family or other natural resources on their own.

     OR
   - The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
     - Maintain their current living situation;
     - Return to work or school.

     OR
   - The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include the following:
     - Assistance with developing the skills needed to self-manage medications.
     - Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.
2. Criteria for Overnight Housing Coupled with a Partial Hospital Program
   - Overnight housing is covered by the benefit plan.
     AND
   - The treatment setting is separate from the housing.
     AND
   - An unsupportive or high-risk living situation is undermining the member's recovery.
     OR
   - Routine attendance at the Partial Hospital is hindered by the lack of transportation. Unsupportive or high-risk living situation is undermining the member's recovery.

MENTAL HEALTH: PSYCHIATRIC MEDICAL INSTITUTION FOR CHILDREN

A Psychiatric Medical Institution for Children (PMIC) is a non-secure institution that provides 24 hours of continuous care and diagnostic or long-term psychiatric services to children (under age 21). All PMICs – which provide mental health and substance related services – must be licensed by the state of Iowa as a PMIC, and they must utilize a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of members in accordance with a medical care plan developed for each member. PMICs must provide social and rehabilitative services under the direction of a qualified mental health professional.

1. Admission Criteria

    - The member has been assigned a DSM diagnosis.
      AND
    - Treatment at a lower level of care was insufficient in the last three months
      AND
    - The member's meets two of the following:
        - The member is a danger to self or others without 24-hour care;
        - The member lacks support for age appropriate development, and/or
        - The member needs occasional medical observation or care.

      AND
    - The member needs 24-hour care due to impairment in one of the following areas due to his/her condition:
        - Impairments in judgment, impulse control, cognition or perception.
        - Social, interpersonal and family relationship impairments in addition to unsuccessful treatment efforts with family.
        - Educational and occupational impairments in addition to unsuccessful treatment efforts with family.

2. Continued Service Criteria

    - There is validation of the member's DSM diagnosis
      AND
    - There is a high likelihood that active treatment intervention will benefit the member.
      AND
    - There is progress toward the member's goals and the member is cooperating with the treatment plan.
      AND
    - The member's symptoms at the time of admission continue to require active treatment or there are new symptoms that have developed requiring active treatment at this level of care.

MENTAL HEALTH: RESIDENTIAL BEHAVIORAL HEALTH INTERVENTION

Residential behavioral health intervention is available to youth members under the age of 18 placed in foster group care. Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services may include:

- Behavioral Intervention – Behavior intervention is covered only for Medicaid members aged 18or under. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.
- Crisis Intervention – Crisis intervention is covered only for Medicaid members aged 18 or under. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists. Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.
- Family Training – Family training is covered only for Medicaid members aged 18 or under. Family training services shall:
    - Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

- Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.
- Training provided must:
  - Be for the direct benefit of the member.
  - Be based on a curriculum with a training manual.

Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

- Cognitive flexibility skills
- Communication skills
- Conflict resolution skills
- Emotional regulation skills
- Executive skills
- Interpersonal relationship skills
- Problem-solving skills
- Social skills

1. Admission Criteria
   - The member has been assigned a DSM diagnosis that impairs the member's independent functioning relative to primary aspects of daily living as determined by a licensed practitioner of the healing arts acting within the practitioner's scope of practice as allowed under state law.
   - Qualified practitioners currently include physicians, advanced registered nurse practitioners, psychologists, independent social workers (MSW, LISW), marital and family therapists, and mental health counselors.
     AND
   - Behavior Intervention is medically necessary[iv].
     AND
   - Services address mental and functional disabilities that negatively affect the member's integration and stability in the community and quality of life, and reduce or manage the behaviors that interfere with the member's ability to function.
     AND
   - Services are designed to reduce or eliminate the symptoms or behaviors resulting from the member's condition that prevent the member from functioning at his/her best functional level.
     AND
   - The focus of the interventions is to improve the member's health and well-being using cognitive, behavioral, or social interventions designed to ameliorate specific diagnosis-related problems.
     AND
   - Services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.
     AND
   - Services must be directed toward the child.

MENTAL HEALTH: RESIDENTIAL TREATMENT CENTER

A facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.

The course of treatment in a Residential Treatment Center is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care.

1. Admission Criteria
   - The member is not in imminent or current risk of harm to self, others, and/or property.
     AND

- The factors leading to admission cannot be safely, efficiently or effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors. Examples include the following:
    - Acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.
- Psychosocial and environmental problems that are likely to threaten the member's safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

MENTAL HEALTH: SUBACUTE

Subacute treatment is designed to resolve the presence of acute or crisis mental health symptoms, or the imminent risk of onset of acute or crisis mental health symptoms for members experiencing a decreased level of functioning due to a mental health condition.

The Subacute treatment setting provides a protective environment that includes stabilization, support, diagnostic evaluation and treatment, wellness, and transition to ongoing services provided 24 hours a day, 7 days a week. Subacute mental health care facilities are intended to be short-term, intensive, recovery-oriented and services are designed to stabilize the member (481 IAC 71.1).

1. Admission Criteria for Subacute Mental Health Care Facilities
    - The member must meet all of the following criteria - Eligibility for individualized subacute mental health services will be determined by the standardized preadmission screening utilized by the facility, which shall be conducted by a mental health professional, as defined in Iowa Code section 228.1(6).
    - In order to be admitted, the individual must:
        - Be 18 years or older;
        - During the past year, have had a diagnosable mental, behavioral or emotional disorder that meets the diagnostic criteria specified in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
        - Demonstrate a high degree of impairment through significantly impaired mental, social, or educational functioning arising from the psychiatric condition or serious emotional disturbance;
        - Demonstrate an impairment that severely limits the skills necessary to maintain an adequate level of functioning outside a treatment program and requires active treatment to obtain an adequate level of functioning;
        - Demonstrate a low level of stability through any two of the following conditions:
    - The individual presents moderate to high risk of danger to self or others.
    - The individual lacks adequate skills or social support to address mental health symptoms.
    - The individual is medically stable but requires observation and care for stabilization of a mental health condition or impairment.
2. Continued Stay Criteria for Subacute Mental Health Care Facilities
    - By the tenth day following admission and every ten calendar days thereafter, the mental health professional shall conduct and document an assessment of the resident and determine if:
        - The severity of the behavioral and emotional symptoms continues to require the subacute level of intervention and the DSM diagnosis remains the principal diagnosis.
        - The prescribed interventions remain consistent with the intended treatment plan outcomes.
        - There is documented evidence of active, individualized discharge planning.
        - There is a reasonable likelihood of substantial benefit in the resident's mental health condition as a result of active intervention of the 24-hour supervised program.
        - Symptoms and behaviors that required admission are continuing.
        - A less intensive level of care would be insufficient to stabilize the resident's condition.
        - New issues that meet the admission guidelines in sub-rule 71.13(2) have appeared.
        - The resident requires further stabilization subsequent to acute care to treat active mental health symptoms such as psychosis, depression or mood disorder.

MENTAL HEALTH: TESTING

The Psychological and Neuropsychological Testing 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.

The Psychological and Neuropsychological Testing Guidelines is derived from generally accepted standards of practice for psychological and neuropsychological testing. 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 Psychological and Neuropsychological Testing Guidelines is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.

WRAPAROUND SERVICES: ASSERTIVE COMMUNITY TREATMENT

Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

Assertive Community Treatment is focused on addressing the factors that precipitated access to this service to the point that the member's condition can be safely, efficiently and effectively treated without the support of Assertive Community Treatment.

1. Admission Criteria

   The member is at least 17 years old.
   AND
   The member meets Iowa's definition of Severe and Persistently Mentally Ill[v].
   AND
   The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:
   - A pattern of repeated episodes of unsuccessful treatment with at least two hospitalizations within the previous 24 months, or
   - A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

   AND
   - There is a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining functioning in the community. Examples of reasonable likelihood is when the member:
     - Is medically stable;
     - Does not require a level of care that includes more intensive medical monitoring;
     - Presents a low risk to self, others, or property, with treatment and support; and
     - Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

   AND
   - The factors that precipitated admission indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
     - The member primarily relies on the Emergency Room for behavioral health services.
     - Impairment of behavior or cognition interferes with Activities of Daily Living to the extent that the member requires significant support or assistance.
2. Continued Service Criteria

- The ACT team participates in all mental health services provided to the member and provide 24-hour service for the psychiatric needs of the member as described in the Clinical Best Practices section of this guideline.

WRAPAROUND SERVICES: COMMUNITY-BASED BEHAVIOR INTERVENTION

Community-based behavioral health intervention is available to Medicaid members living in a community-based environment and the primary goal is to assist the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Community-Based Behavioral Health Intervention is provided in a location appropriate for skill identification, teaching, and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs. Depending on the member's age and diagnosis, specific services may include:

- Behavioral Intervention – Behavior intervention is covered only for Medicaid members aged 20 or under. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.
- Crisis Intervention – Crisis intervention is covered only for Medicaid members aged 20 or under. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists. Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.
- Family Training – Family training is covered only for Medicaid members aged 20 or under. Family training services shall:
    - Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
    - Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.
    - Training provided must:
        - Be for the direct benefit of the member.
        - Be based on a curriculum with a training manual.
- Skill Training and Development – Skill training and development is covered only for Medicaid members who are aged 18 and older. Skill training and development includes interventions to enhance independent living, social and communication skills that minimize or eliminate psychological barriers to a member's ability to manage symptoms associated with a psychological disorder effectively and maximize the member's ability to live and participate in the community.

Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

- Cognitive flexibility skills
- Communication skills
- Conflict resolution skills
- Emotional regulation skills
- Executive skills
- Interpersonal relationship skills
- Problem-solving skills
- Social skills
- Daily living skills.

1. Admission Criteria
    - Behavior Intervention is medically necessary[vi].
      AND
    - Services address mental and functional disabilities that negatively affect the member's integration and stability in the community and quality of life, and reduce or manage the behaviors that interfere with the member's ability to function.
      AND
    - Services are designed to reduce or eliminate the symptoms or behaviors resulting from the member's condition that prevent the member from functioning at his/her best functional level.

AND

- The focus of the interventions is to improve the member's health and well-being using cognitive, behavioral, or social interventions designed to ameliorate specific diagnosis-related problems.
  AND
- Services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.
  AND
- Services must be directed toward the child with the exception of skill training and development.

WRAPAROUND SERVICES: DAY HABILITATION

These services assist or support the member in developing or maintaining life skills and community integration. Services shall enable or enhance the member's functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

Services are provided for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan.

Provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help; socialization and adaptive skills that enhance social development; and development of skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the member's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

1. Admission Criteria
   - The member is enrolled in the HCBS State Plan Habilitation Program.
     AND
   - Day Habilitation is medically necessary[vii].
     AND
   - The member's functioning is impaired in two or more of the following areas due to severe symptoms of his/her mental illness:
     - Housing (accessing or maintaining),
     - Employment/education,
     - Financial management,
     - Transportation,
     - Ability to obtain needed support services,
     - Social relationships/supports,
     - Basic daily living skills,
     - Health/medical management

     AND
   - The member is not in imminent or current risk of harm to self, others, and/or property.
     AND
   - The factors that precipitated admission indicate that the member requires assistance with the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice.

WRAPAROUND SERVICES: FAMILY AND COMMUNITY SUPPORT SERVICES

Children's Mental Health Waiver

Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression, and will increase the child's and family's social and emotional strength.

Depending on the needs of the child and family members (individually or collectively), family and community support services may be provided to the child, to the child's family members, or to the child and family members as a family unit.

This service shall be provided under the recommendation and direction of the mental health professionals that are included in the child's interdisciplinary team.

1. Admission Criteria
    - The member is enrolled in the Children's Mental Health Waiver
      AND
    - The member is not at imminent risk of harm to self or others.
      AND
    - If co-occurring mental health and substance use disorders or co-morbid medical conditions are present, they can be safely managed.
      AND
    - The member and family require support interventions and activities to include the following:
        - Developing and maintaining a crisis support network for the member and for the member's family
        - Modeling and coaching effective coping strategies for the member's family members.
        - Building resilience to the stigma of serious emotional disturbance for the member and the family.
        - Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
        - Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.
        - Developing medication management skills.
        - Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
        - Developing positive socialization and citizenship skills.

2. Continued Service Criteria
    - The responsible provider has evaluated the member and caregiver's needs upon admission.
      AND
    - The responsible provider in conjunction with the member and/or family or caregiver when applicable, develops a plan that includes the following:
        - The goals of family and community supports; and
        - Specific, measurable objectives aimed achieving the goals of family and community support.

      AND
    - The person-centered plan is informed by the findings of the initial assessment.
      AND
    - Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

WRAPAROUND SERVICES: HABILITATION CASE MANAGEMENT

Case Management is a community-based program in which a behavioral health professional or trained peer assists members who are at risk of being underserved in their effort to identify, access and utilize home and community-based habilitation services as well as medical, behavioral health or social services, or to otherwise achieve recovery and resiliency goals. Case Management is focused on addressing the factors that precipitated access to this service to the point that the member's condition can be safely, efficiently and effectively treated without the support of Case Management.

Case Management may be mobile or delivered in an outpatient treatment setting.

Case management services vary in intensity, frequency, and duration in order to support the member's ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

Case management may only be provided as a service through the habilitation program to a member who is not enrolled in an integrated health home and is not authorized to receive Medicaid targeted case management under 441 IAC Chapter 90.

1. Admission Criteria

    - The member is enrolled in the HCBS State Plan Habilitation Program.
      AND
    - Case Management Habilitation is medically necessary[viii].
      AND
    - The member is not in imminent or current risk of harm to self, others, and/or property.
      AND
    - The factors that precipitated admission indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:
        - The member requires assistance accessing home and community habilitation services.
        - The member requires assistance with navigating the system of care.
        - The member requires assistance with accessing transportation services, employment services, childcare or other community resources.

WRAPAROUND SERVICES: HOME-BASED HABILITATION

Home-based habilitation consists of individualized services and supports that assist individuals with severe mental illnesses with the acquisition, retention, or improvement in skills related to living in their home in the community. Examples include assistance with medication management, budgeting, grocery shopping and personal hygiene skills. HBH services are managed by the member's Integrated Health Home based on the member's person-centered service plan developed by the member, their interdisciplinary team, people of the member's choosing, and IHH staff. The plan is maintained by IHH staff, the habilitation supervisor, in-home nursing resources, the psychiatrist and any additional treatment providers as required.

These services are provided in the member's home or community up to 24-hours a day and assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and can be provided at any time of day or night that is necessary to meet the member's needs.

1. Admission Criteria
    - The member is enrolled in the HCBS State Plan Habilitation Program.
      AND
    - Home-Based Habilitation is medically necessary[ix].
      AND
    - The member's functioning is impaired in two or more of the following areas due to severe symptoms of his/her severe mental illness:
        - Housing (accessing or maintaining),
        - Employment/education,
        - Financial management,
        - Transportation,
        - Ability to obtain needed support services,

- Social relationships/supports,
- Basic daily living skills,
- Health/medical management

AND

- The member lacks the ability to adequately perform activities or tasks of daily living in a manner that would allow him/her to function in day-to-day community life without Habilitation supports.

AND

- The member is not in imminent or current risk of harm to self, others, and/or property.

AND

- The factors that precipitated admission indicates that the member requires with the acquisition, retention, or improvement in skills related to living in their home in the community.
  - Examples include assistance with medication management, budgeting, grocery shopping and personal hygiene skills.

AND

- The member meets ONE of the following level specific criteria (I, II, III, Recovery or Medium):
  - **Intensive III: 17 to 24 hours per day every day**
    - There has been a recent hospital stay(s), use of emergency room services, or presence of significant risk of harm/disturbance in mood rendering the member unable to care for him/herself.

      AND
    - This service has approval by the member's psychiatrist or other appropriate clinician. The clinician provides written justification in the member's file for the need for services up to 24 hours per day.

      AND
    - Service activities are aimed at stabilization.
    - NOTE: This level is transitional with the goal of stabilization of risk to self or others. Frequency of service is daily.
  - **Intensive II: 13 to 16.75 hours per day every day**
    - The member can maintain for periods of time without the need for immediate staff presence and intervention.

      AND
    - Thoughts or actions of significant self-harm/harm to others have reduced and are better managed without 24 hour staffing.

      AND
    - Structured and meaningful activity outside the member's residence is being developed by the Integrated Health Home.

      AND
    - Safety and supervision is necessary for most waking hours of the day.

      AND
    - The member needs significant support to complete basic living skills.

      AND
    - Service activities are aimed at stabilizing the member's daily routine, including but not limited to, supporting the member to complete activities of daily living to improve skill competency and independence.
    - NOTE: This level is transitional with the goals of developing structured and meaningful activity outside of the member's residence and stabilization of his/her daily routine. Frequency of service is daily.
  - **Intensive I: 9 to 12.75 hours on the days of service**
    - The member is free from thoughts of significant self-harm to self or others.

      AND
    - The member requires significant support/skills interventions with:
      - Problem solving.
      - Emotional management.
      - Coping skills.

        - Relaxation/self-regulation.
        - Crisis planning and implementation.
        - Other individualized skills identified by member.

      AND
    - The member requires assistance to increase participation in the community (e.g., working, volunteering and other meaningful opportunities identified by the member).

      AND
    - Service activities are aimed at helping the member prepare for greater independence and community integration.
    - NOTE: This level is transitional. Frequency of service is daily. It should be possible to move the member from Intensive II directly to Medium in most situations. Exceptions can include severe anxiety or other symptoms that require this continued level of staff intervention. This support should be decreased as appropriate to assist optimal individual functioning.
- **Medium Need: 4.25 to 8.75 hours on the days of service**
    - The member is free from significant self -harm or harm to others

      AND
    - The member requires significant support/skills interventions with:
        - Problem solving.
        - Emotional management.
        - Coping skills.
        - Relaxation/self-regulation.
        - Crisis planning and implementation.
        - Other individualized skills identified by member.

      AND
    - The member has demonstrated increased participation in the community (e.g., working, volunteering and, other meaningful opportunities identified by the member).

      AND
    - The member is capable of performing basic daily living activities.

      AND
    - Service activities are aimed at helping the member prepare for greater independence and community integration. Frequency of service is dependent on individual needs.
- **Recovery Transitional: 2.25 to 4 hours on the days of service**
    - The member needs periodic contact for medication adherence and/or monitoring of status and recovery maintenance.

      AND
    - The member good use of community, family and other natural supports.

      AND
    - The member engages in purposeful activity in line with the member's values and beliefs.

      AND
    - The member has made significant progress in managing a daily routine without staff intervention.

      AND
    - The frequency of service is based on individual needs.
- **High Recovery: .25 to 2 hours on the days of service**
    - The member needs periodic contact for medication adherence and/or monitoring of status and recovery maintenance.

      AND
    - The member demonstrates good use of community, family and other natural supports.

      AND
    - The member is engaging in purposeful activity in line with his/her values and beliefs.

AND

- The member is making progress in managing their daily routine without staff intervention.

WRAPAROUND SERVICES: PEER SERVICES AND SUPPORTS

Peer Services and Supports provide members with support, information, and the opportunity to develop skills in support of the member's recovery. While providing these services, the Peer utilizes his/her training, lived experience and experiential knowledge to reduce the likelihood that the member will become isolated, disempowered, or disengaged. Peer services and Supports is focused on addressing the factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated without the support of Peer Services and Supports

Peer Services and Supports complement the member's behavioral health treatment, and may be delivered while the member is in treatment or in advance of the start of treatment.

Peer Services and Supports vary in intensity, frequency and duration in accordance with the member's ability to utilize behavioral health services, manage psychosocial challenges, or otherwise make progress in achieving the member's recovery goals.

1. Admission Criteria
    - The member has a Serious Mental Illness (SMI)[x] or a Substance-Related Disorder.
      AND
    - The member is not in imminent or current risk of harm to self, others, and/or property.
      AND
    - The factors that precipitated access to this service indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
        - The member requires information about their behavioral health condition, evidence-based treatment, approaches to self-care, or community resources.
        - The member could benefit from learning skills related to problem-solving, communication, managing crises or stress, activating and engaging in self-care, or promoting recovery.
        - The member requires assistance navigating the system of care.

      AND
    - The member is receiving behavioral health services, or is likely to engage in treatment with the provision of Peer Services and Supports.

WRAPAROUND SERVICES: PREVOCATIONAL HABILITATION

Prevocational Habilitation services are services that provide learning and work experiences, including volunteer work, where the member can develop general, non-job-task-specific strengths and skills that contribute to eventual employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved through an ongoing person-centered service planning approach.

Members receiving prevocational services must have employment-related goals in their person-centered services and supports plan. The general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services.

Prevocational services may be furnished in a variety of locations in the community and are not limited to fixed-site facilities.

1. Admission Criteria
    - The member is enrolled in the HCBS State Plan Habilitation Program.
      AND
    - Home-Based Habilitation is medically necessary.
      AND

- The member has chosen to participate in activities to support the process of acquiring and maintaining employment.
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- The factors that precipitated admission indicates that the member requires assistance with learning and work experiences, including volunteer work, where the member can develop general, non-job-task-specific strengths and skills that contribute to eventual employability.
  AND
- At minimum the following Prevocational Habilitation services and activities should be available to the member:
  - Teaching such concepts as adherence, attendance, task completion, problem solving, and safety.
  - Providing scheduled activities outside of a member's home that support acquisition, retention, or improvement of job-related skills related to self-care, sensory-motor skills, daily living skills, communication, community living, social and cognitive skills.
  - Gaining work-related experience considered crucial for job placement (e.g., time-limited unpaid internship).

WRAPAROUND SERVICES: RESPITE CARE

Children's Mental Health

Respite care services are services provided to the member that gives temporary relief to the usual caregiver and provides all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- Specialized respite means respite provided on a staff to member ratio of one to one or higher for individuals with specialized medical needs requiring monitoring or supervision provided by a licensed registered nurse or licensed practical nurse.
- Group respite means respite provided on a staff to member ratio of less than one to one.
- Basic individual respite means respite provided on a staff to member ratio of one to one or higher for individuals without specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

Respite may be provided in the member's home, another family's home, day and overnight camps, organized community programs, hospitals, foster group care, foster family home, a licensed daycare, or a respite provider that is certified..

1. Admission Criteria
   - The member is enrolled in the Children's Mental Health Waiver.
     AND
   - The member is willing to voluntarily receive respite and willing to be assessed by a treating professional.
     AND
   - The member is not at imminent risk of harm to self or others.
     AND
   - If co-occurring mental health and substance use disorders or co-morbid medical conditions are present, they can be safely managed.
     AND
   - The member needs the support of respite services so that the member can remain in his/her current living situation.
     AND
   - The member's interdisciplinary team has determined whether the member will receive individual, group, day or overnight camp or specialized respite according to the needs of the member.
     AND

- The member is actively engaged in outpatient treatment and/or community-based services.

2. Continued Service Criteria
   - The responsible respite provider has evaluated the member and caregiver's needs upon admission.
     AND
   - The responsible respite provider in conjunction with the member and/or family or caregiver when applicable, develops a respite plan that includes the following:
     - The goal of Respite; and
     - Specific, measurable objectives aimed achieving the goal of Respite.

     AND
   - The respite plan is informed by the findings of the initial assessment.
     AND
   - Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

3. Discharge Criteria
   - There is a maximum of 14 consecutive days of 24-hour respite allowed.

WRAPAROUND SERVICES: SUPPORTED EMPLOYMENT/INDIVIDUAL EMPLOYMENT HABILITATION

SEIE supports may be furnished to any member who requires and chooses them through a person-centered planning process. They are not limited to persons with intellectual or developmental disabilities.

SEIE support services are the ongoing supports to members who, because of their disabilities, need intensive ongoing support to obtain and maintain employment. Supports are provided to members employed in a competitive or customized job, or to members who are self-employed. Members shall be integrated into the general workforce and compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

1. Admission Criteria
   - The member is enrolled in the Home and Community Based State Plan Habilitation Program.
     AND
   - Home-Based Habilitation is medically necessary[xi].
     AND
   - The member has chosen to participate in activities to support the process of acquiring and maintaining employment.
     AND
   - The member is not in imminent or current risk of harm to self, others, and/or property.
     AND
   - The factors that precipitated admission indicates that the member needs intensive ongoing support to obtain and maintain employment.
     AND
   - At minimum the following Supported Employment Habilitation services and activities should be available to the member:
     - Providing time-limited employment and on-the-job training in one or more integrated employment settings as an integral part of the individual's vocational rehabilitation growth.
     - Providing support to members in order to gain skills to enable transition to integrated, competitive employment.

- Training activities provided in regular business, industry, and community settings.
- Promoting integration into the workplace and interaction between members and people without disabilities in those workplaces.
- Providing on the job supports, (e.g., initial and ongoing employment planning and advancement, employment assessment, job placement, job development, negotiation with prospective employers, job analysis, training, coaching, instruction and transportation).
- Providing services not specifically related to job skill training that enable the member to be successful integrating into the job setting.
- Intensive Supported Employment:
- Assisting the member to locate a job or develop a job on behalf of the member via the use of individualized placement and support services that include rapid job search.
- Supporting the member to establish or maintain self-employment, including home-based self-employment.
- Providing ongoing vocational/job-related discovery or assessment.
- Providing activities needed to sustain paid work by participants, including supervision and training.
- Providing reminders of effective workplace practices and reinforcement of skills already gained.

WRAPAROUND SERVICES: TARGETED CASE MANAGEMENT

TCM is a service to manage multiple resources effectively for the benefit of Medicaid members. TCM services assist members in gaining access to appropriate and needed medical and interrelated social, educational, housing, transportation, vocational, and other services. The goal of targeted case management is to ensure that:

- Necessary evaluations are conducted.
- Individual services and treatment plans are developed, implemented, monitored, and modified as necessary.
- Reassessment of member needs and service provision occurs on an ongoing and regular basis (minimum of once a year).

1. Admission Criteria

    - Targeted Case Management is medically necessary and the member meets the definition of chronically mentally ill.
      AND
    - The member meets at least one of the following risk factors:
        - The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization); or
        - The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

      AND
        - The member has a need for assistance typically demonstrated by meeting the following criteria on a continuing or intermittent basis for at least two years:
        - The member is unemployed or employed in a sheltered setting or has markedly limited skills and a poor work history; and
        - The member requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help
        - The member shows severe inability to establish or maintain a personal social support system.
        - The member requires help in basic living skills.
        - The member exhibits inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

      AND

- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- The factors that precipitated admission indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:
  - The member has a need for TCM to manage multiple resources pertaining to medical and interrelated social and education services for the benefit of the member.
  - The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.

  AND
- The member is not receiving other paid benefits under the Medicaid program or under a Medicaid managed health care plan that serve the same purpose as targeted case management.

REFERENCES

Iowa Code 514C.28. Autism Spectrum Disorder Coverage.

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REVISION HISTORY

Date	Action/Description
03/01/2017	Version 1 for all with the exception of Crisis Services and Subacute
06/13/2018	Version 2 for all with the exception of Crisis Services and Subacute
06/13/2018	Version 1 for Crisis Services and Subacute

[i] For ABA, this means medically necessary and resulting in the development, maintenance, or restoration, to the maximum extent practicable, of the functioning of an individual.
"Department" means the department of human services.

[ii] According to Federal Register 58, Number 96, the 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] Boston University Center for Psychiatric Rehabilitation, A Primer on the Psychiatric Rehabilitation Process, definition of Psychiatric Rehabilitation, 2009.

[iv] To be payable by Medicaid as a behavioral health intervention service, a service must be:

- Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental health disorder.
- Rehabilitative in nature and not habilitative.
- Designed to promote a member's integration and stability in the community and quality of life
- Consistent with professionally accepted guidelines and standards of best practice for the service being provided.
- Designed to promote a member's ability to obtain or retain employment or to function in non-work settings.
- Designed to address mental and functional disabilities and behaviors resulting from a psychological disorder that interferes with an individual's ability to live and participate in the community.
- Furnished in the most appropriate and least restrictive available setting in which the service can be safely provided, consistent with the member's goals identified in the treatment plan and defined in the member's implementation plan.
- Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver.
- In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
    - Knowledgeable Iowa clinicians practicing or teaching in the field, and
    - The professional literature regarding evidence-based practices in the field.

[v] 1.1. A Severe and Persistent Mental Illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, familial, educational or vocational roles).
The member has a degree of impairment arising from the member's Severe and Persistent Mental Illness to the degree that:
1.1.The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;
1.2.The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and/or
1.3. The member exhibits significant impairment in social, interpersonal, or familial functioning.

[vi] To be payable by Medicaid as a behavioral health intervention service, a service must be:

- Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental health disorder.
- Rehabilitative in nature and not habilitative.
- Designed to promote a member's integration and stability in the community and quality of life
- Consistent with professionally accepted guidelines and standards of best practice for the service being provided.
- Designed to promote a member's ability to obtain or retain employment or to function in non-work settings.
- Designed to address mental and functional disabilities and behaviors resulting from a psychological disorder that interferes with an individual's ability to live and participate in the community.
- Furnished in the most appropriate and least restrictive available setting in which the service can be safely provided, consistent with the member's goals identified in the treatment plan and defined in the member's implementation plan.
- Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver.
- In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
    - Knowledgeable Iowa clinicians practicing or teaching in the field, and
    - The professional literature regarding evidence-based practices in the field.

[vii] To be payable by Medicaid as a habilitation service, a service must (IAC 441-78.27(5)):

- Be reasonable and necessary.
- Be based on the member's needs as identified in the member's comprehensive service plan.
- Be delivered in the least restrictive environment appropriate to the needs of the member.
- Be provided at the most appropriate level for the member.
- Include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- Be consistent with professionally accepted guidelines and standards of practice for the service being provided.

[viii] To be payable by Medicaid as a habilitation service, a service must:

- Be reasonable and necessary.
- Be based on the member's needs as identified in the member's comprehensive service plan.
- Be delivered in the least restrictive environment appropriate to the needs of the member.
- Be provided at the most appropriate level for the member.
- Include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- Be consistent with professionally accepted guidelines and standards of practice for the service being provided.

[ix] To be payable by Medicaid as a habilitation service, a service must:

- Be reasonable and necessary.
- Be based on the member's needs as identified in the member's comprehensive service plan.
- Be delivered in the least restrictive environment appropriate to the needs of the member.
- Be provided at the most appropriate level for the member.
- Include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- Be consistent with professionally accepted guidelines and standards of practice for the service being provided.

[x] According to Federal Register 58, Number 96, the 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.

[xi] To be payable by Medicaid as a habilitation service, a service must:

- Be reasonable and necessary.
- Be based on the member's needs as identified in the member's comprehensive service plan.
- Be delivered in the least restrictive environment appropriate to the needs of the member.
- Be provided at the most appropriate level for the member.
- Include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- Be consistent with professionally accepted guidelines and standards of practice for the service being provided.