



United Behavioral Health

## Supplemental Clinical Criteria: Kansas Medicaid

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### INTRODUCTION & INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*<sup>1</sup> defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

Other *Clinical Criteria*<sup>2</sup> may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®<sup>3</sup>. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required,

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

<sup>2</sup> **Clinical Criteria**

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

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

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

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

<sup>3</sup> Optum is a brand used by United Behavioral Health and its affiliates.

or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

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

## EVIDENCE-BASED PRACTICE CRITERIA

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

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

## ATTENDANT CARE

**Attendant Care** Attendant Care is a service provided to a child or adolescent with a Serious Emotional Disturbance or an adult with a Severe and Persistent Mental Illness who would otherwise be placed in a more restrictive setting due to functional impairment resulting from an identified

behavioral health conditions. This service enables the member to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Attendant Care is not covered when provided to a member who is in a hospital, nursing facility, intermediate care facility for persons with mental retardation, or an institution for mental diseases.

Attendant Care is delivered by paraprofessional who has completed state-approved training.

### Admission Criteria

- The member is not in a hospital, nursing facility, intermediate care facility for persons with mental retardation, or an institution for mental diseases.  
AND
- The member requires assistance performing tasks or engaging in activities. Examples include:
  - The member requires direct support, supervision and/or cuing so that the member performs tasks of activities by him/herself.
  - The member requires assistance with Activities for Daily Living and Instrumental Activities for Daily Living, and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community.
- AND
- The member is likely to need Inpatient services in the absence of Attendant Care.  
AND
- Attendant Care is recommended by the member's treatment team.  
AND
- The member is not in imminent or current risk of harm to self, others, and/or property.  
AND
- Co-occurring behavioral health or medical-surgical conditions can be safely managed.  
AND
- The member and the member's family are willing and available to actively participate in Attendant Care.  
AND
- Care is medically necessary<sup>i</sup>.  
AND *for Children and Adolescents*
- The member meets criteria for a Serious Emotional Disturbance.  
AND *for Adults*
- The member meets criteria for a Severe and Persistent Mental Illness<sup>ii</sup>.

## COMMUNITY PSYCHIATRIC SUPPORT AND TREATMENT (CPST)

**Community Psychiatric Support and Treatment** Community Psychiatric Support and Treatments (CPST) are goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the member's individualized treatment plan. CPST is a face-to-face intervention with the member present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the member lives, works, attends school, and/or socializes.

### Admission Criteria

- Adults, Children and Adolescents
  - The Member has a behavioral health condition meeting the criteria for a qualified DSM diagnosis<sup>iii</sup> which has created a reduced level of functioning<sup>iv</sup> and subjective distress.  
AND
  - Care is medically necessary<sup>v</sup>.  
AND
  - Less intensive services would not be adequate to assist the member in reaching identified treatment goals.  
AND
  - Co-occurring mental health and substance use disorders and/or co-morbid physical conditions can be safely managed.  
AND

- In collaboration with the CPST provider, the member is willing and able to connect with individual natural supports, community resources and activities that will enable community integration.
- Adults with SPMI
  - In addition to the Admission Criteria for Adults, Children and Adolescents, the member meets the State's criteria for Severe and Persistent Mental Illness.
- AND
- Children and Adolescents with SED
  - In addition to the Admission Criteria for Adults, Children and Adolescents, the member meets the State's criteria for Serious Emotional Disturbance.

### Service Delivery

- A periodic review of the service plan shall include the following:
  - Input of all staff involved in treatment of the member;
  - The member, his or her family and/or other collaterals, as appropriate;
  - Assessment of the progress of the member in regard to the mutually agreed upon goals in the service plan;
  - Adjustment of goals, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate; and
  - The signature of the physician involved in the treatment.
- AND
- CPST may include the following components:
  - Assisting the member and family members or other collaterals to identify strategies or treatment options associated with the member's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the member's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
  - Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the member, with the goal of assisting the member to develop and implement social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.
  - Participation in and use of strengths-based planning and treatments, which include assisting the member and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and objectives; and to use personal strengths, resources, and natural supports to address functional deficits associated with the member's mental illness.
  - Assisting the member with effectively responding to or avoiding identified precursors or triggers that would risk the member remaining in a natural community location, including assisting the member and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or as appropriate, to seek other supports to restore stability and functioning.

### COMMUNITY BASED WRAPAROUND FACILITATION

**Wraparound Facilitation** is to form a wraparound team consisting of the member's family, extended family, and other community members involved with the member's daily life for the purpose of producing a community-based, individualized Plan of Care. This includes working with the family to identify who should be involved in the wraparound team and assembly of the wraparound team for the Plan of Care development meeting.

### Admission Criteria

- 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 waiver member's medical record.

- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.
- A provider can perform 30 minutes of Case Conference during a Wraparound Facilitation meeting.

### Service Delivery

- The wraparound facilitator guides the Plan of Care development process.
- The wraparound facilitator also is responsible for reassembling the team when subsequent Plan of Care review and revision are needed, at minimum on a yearly basis to review the Plan of Care and more frequently when changes in the member's circumstances warrant changes in the Plan of Care.
- The wraparound facilitator will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the waiver member and family/caregivers.
- Facilitators will be certified after completion of specialized training in the wraparound philosophy, waiver/grant rules and processes, waiver/grant eligibility and associated paperwork, structure of the waiver member and family team, and meeting facilitation.
- Limitations include:
  - Wraparound Facilitation is provided in addition to targeted case management to address the unique needs of waiver members living in the community and does not duplicate any other Medicaid State Plan service or services otherwise available to the waiver member at no cost.

## INDEPENDENT LIVING

**Independent Living** Independent Living/Skills Building services are designed to assist members who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings.

### Admission Criteria

- Services include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the member.
  - Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the member's medical record;
- AND
- All Independent Living services will be provided in the community:
  - For example community settings could encompass: a grocery or clothing store, (teaching the young person how to shop for food, or what type of clothing is appropriate for interviews), unemployment office (assist in seeking jobs, assisting the youth in completing applications for jobs), apartment complexes (to seek out housing opportunities), Laundromats (how to wash their clothes);
- AND
- Services will include:
  - Learning cues for normal activities of daily living and instrumental activities of daily living.
  - Housekeeping, homemaking (shopping, child care and laundry services) or basic services, solely for the convenience of a child receiving independent living/skills building, are not covered.
  - Life safety skills, ability to access emergency services, basic safety practices and evacuation.
  - Physical and mental health care (maintenance, scheduling physician appointments), recognizing when to contact a physician, self-administration of medication for physical and mental health conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses.

- Use of transportation (accessing public transportation, learning to drive, obtaining insurance).

### Service Delivery

- Components of Independent Living/Skills Building
  - Independent Living/Skills Building activities are provided in partnership with members to help arrange for the services needed to become employed, find transportation, housing, and continue their education.
  - Services are individualized according to each member's strengths, interests, skills, goals as specified in the Plan of Care.
  - It would be expected that Independent Living/Skills Building activities take place in the community.
  - This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living.
  - Housekeeping, homemaking (shopping, child care, and laundry services), or basic services solely for the convenience of a member receiving independent living /skills building are not covered.
  - The following are examples of appropriate community settings rather than an all-inclusive list:
    - a grocery store to shop for food;
    - a clothing store to teach the member what type of clothing is appropriate for interviews;
    - an unemployment office to assist in seeking jobs or assist the member in completing applications for jobs;
    - apartment complexes to seek out housing opportunities, and
    - Laundromats to teach the member how to wash clothing;
    - Other appropriate activities can be provided in other community setting as identified through the Plan of Care process.
- Transportation is provided between the member's place of residence and other services sites and places in the community and the cost of transportation is included in the rate paid to providers of this service.

## OPERATION COMMUNITY INTEGRATION

**Operation Community Integration (OCI)** program service model demonstrates how services and supports will be provided in an evidence-based manner such that it enables individuals diagnosed with a behavioral health diagnosis to develop the skills necessary to become fully integrated into their communities, particularly in the areas of community integration, housing, and employment. All support services and interventions must be medically necessary and driven by member choice.

- **Intensive Community Residential Placement Support Services (ICRP)** The ICRP service level of need is targeted towards members whose screening indicates a need for medically necessary intensive on-site residential services, because of a history of unsuccessful integration in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric or incarceration.
- **Intensive Community Integration Support Services (ICI)** is targeted towards members who are unable to tolerate congregate living arrangements in which the presence of other members in their immediate living area tends to precipitate psychiatric and substance abuse relapse, aggression, or other behaviors associated with risk of re-hospitalization or incarceration.

### Admission Criteria (ICRP)

- A DLA 20 screening has been completed by a certified screener indicating the member's level of need.
- The member has a history of unsuccessful integration in multiple community settings; or
- There is a risk of harm to self or others and without ICRP services would require long-term psychiatric care or incarceration.
- The member can tolerate regular interactions with peers.
- The member has significant difficulties with Activities of Daily Living (ADLs).

- The member may require round the clock observation and oversight and/or redirection for potentially harmful behaviors.
- The member's behaviors directly interfere with the member's ability to obtain or sustain independent living in the community.

### **Admission Criteria (ICI)**

- A DLA 20 screening has been completed by a certified screener indicating the member's level of need.
- The member is unable to tolerate congregate living which precipitates psychiatric or substance abuse relapse, aggression, or re-hospitalization or incarceration.
- The member may be sufficiently competent in Activities of Daily Living (ADLs) but has difficulty managing socially appropriate behavior skills needed to obtain sustain permanent housing.
- The member requires direct care staff to ensure the member is not engaging in harmful behaviors towards themselves or others and not participating in activities that involve a high risk of relapse of psychiatric or substance use disorder symptoms that interfere with independent living.

### **Continuing Stay Criteria**

- Copy of the DLA 20 screening tool along with the recommendations made by the certified DLA 20 screener and a treatment plan (completed within 72 hours of admission to the program).
- Treatment plans must be modified and updated as necessary and reviewed with treatment team monthly. Proof of treatment plan review shall be placed in members chart.
- Individuals in Residential Programming Intensive Community Residential Placement (ICRP) level of care must also have entries in a safety log as well as progress notes that reflect safety monitoring, and evidence of periodic safety checks overnight.
- Individuals in the Intensive Community Integration (ICI) level of care must have a critical intervention plan for all members participating in this level of care in the member's individual file.

### **Service Delivery**

- Services are designed to provide medically necessary supports and interventions that are person centered and reflect the needs and choice of the member. Treatment planning and services are done in collaboration with the member and the services used to support the member reflect medical necessity and relate directly to the goal of community integration.
- The core principles of Operation Community Integration shall follow the Service Model for Housing First. At all times services provision shall reflect the following core principles:
  - Access and connection to community supports that offer safe and affordable housing options and identification of supports that will allow member to sustain housing;
  - Daily programming goals and face-to-face interventions needed to reflect the goal of community integration and housing stability in permanent housing;
  - Supports may look different from individual to individual, and shall be based on developmentally appropriate needs and considerations, including those of transition aged youth, elders, persons with criminal records and homeless families;
  - Services should be client driven and targeted to support "housing readiness";
  - Services and treatment planning should address quality of life, health, behavioral health, and employment barriers that can be achieved through permanent supported housing;
  - Services shall be guided by medical necessity and the member's right to choose, self-determination, dignity and respect.
- Services for all OCI members include:
  - Assistance in performing, coaching and skill building around basic daily living and social skills.
  - Coaching and skill building regarding symptom management and community integration.
  - Prompting and skill building for conflict resolution.
  - Collaboration and member participation in HUD's Coordinated Entry System.
  - Recovery coaching and relapse prevention planning.

- Case Management support to assist member with linkage to community resources to obtain and sustain safe, affordable housing.
- Providing landlord/tenant dispute resolution to reduce the risk of eviction or other adverse action.
- Assistance with entitlement advocacy and the application process by a certified SOAR staff member to support community integration.
- Direct face-to-face interventions with members to assist with budget development, budget management, and provide education on the benefits of a budget.
- Referral and collaborative supports to assist member with barriers regarding legal issues.
- Direct supports, prompting and skill building to address anger management issues that interfere with member's ability to successfully integrate into the community through interventions and guided by SAMHSA's Cognitive Behavioral Therapy Intervention work-book.
- Assistance with medication management (which may include Medication Assisted Treatment).
- Assistance with housing option searches, housing applications and securing permanent housing.
- Coordination with social supports and activities that will improve community integration.
- IPS Supported Employment EBP programming for members wanting to obtain employment to support community integration.
- Assistance with creating and developing a housing support crisis plan to address symptom management while reintegrating and residing in the community.
- Mobile Crisis response and stabilization services and/or collaboration with CIT teams- will allow the provider to begin crisis assessment where the at-risk member is located.

## PARENT SUPPORT AND TRAINING

**Parent Support and Training** is a service designed to benefit members experiencing a serious emotional disturbance who without PST would require state psychiatric hospitalization. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member. For the purposes of this service, "family" is defined as the persons who live with or provide care to the member, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

### Admission Criteria

- The member resides with or receives regular care from a "family" member;  
AND
- Services include communication and coordination with the "family";  
AND
- Coordination with other child serving systems occurs as needed to achieve the treatment goals. All coordination is documented in the medical record;  
AND
- The member and the member's "family" are willing and available to actively participate in interventions as identified in the member's plan of care;  
AND
- There is no imminent risk of serious harm to self or others;  
AND
- Co-occurring mental health and substance use disorders and/or co-morbid physical conditions can be safely managed;  
AND

- Providers receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.

### **Continuing Stay Criteria**

- The member's "family" and/or other natural resources and supports are engaged to actively participate in the member's service needs as required by this service.

### **Service Delivery**

- Evaluation and Treatment Planning
  - The provider actively engages and involves the member and "family" members the evaluation, planning and decision making process throughout service delivery with the member's consent. This includes gaining an understanding of the following elements:
    - The strengths and limitations of the "family's" ability to support the member;
    - The immediate questions, challenges and priorities from the "family's" perspective;
    - The level of understanding and current attitudes/approaches the "family" has taken regarding the member's SED;
    - The "family's" capacities, personalities, willingness to take on new roles and developmental stage of the family unit (e.g., family with young children, late-life family, etc.);
    - The "family's" previous experiences providing care to an individual with a SED;
    - The provider determines the quality of the relationship with the member;
    - Any cultural and spiritual considerations relevant to caring for the member; and
    - Identifying any existing mental health symptoms/conditions the "family" members may be experiencing and arranging for referral as appropriate.
  - The service plan summarizes the "family's" goals in the context of the member's overall care plan, and describes what services will be provided to accomplish those goals. The service plan should include the following elements:
    - Coordination of all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative, supportive relationship.
    - Consideration of both the social and the clinical needs of the member and "family."
    - Ensuring the member is receiving optimum medication management and clinical intervention.
    - Listening to the "family's" concerns and involving them as equal partners in the planning and delivery of treatment.
    - Exploring the "family's" expectations of Family Support services and expectations for the member.
    - Developing goals that utilize the family's strengths and also addresses limitations of the "family's" ability to support the member.
    - Helping resolve family conflict by responding sensitively to emotional distress.
    - Addressing feelings of loss.
    - Providing relevant information for the member and his or her "family" at appropriate times.
    - Developing an explicit crisis plan and professional response.
    - Helping improve communication among "family" members.
    - Providing training for the "family" using structured problem-solving techniques.
    - Encouraging "family" members to expand their social support networks (e.g., to participate in family support organizations such as NAMI).
    - Being flexible in meeting the needs of the family.
    - Providing the family with easy access to another professional in the event that the current work with the "family" ceases.
  - Interventions include:
    - Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the eligible child/youth in

relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms and strategies for the child's/youth's symptom/behavior management.

- Assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care (POC) process.
- Training on understanding the child's diagnoses.
- Understanding service options offered by service providers and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other child-serving systems).
- The specialist may also conduct follow-up with the families regarding services provided and continuing needs.

## PROFESSIONAL RESOURCE FAMILY CARE

**Professional Resource Family Care** is intended to provide intensive supportive resources for the member and his or her family. This service offers intensive family-based support for the member's family through the utilization of a co-parenting approach provided to the member in a surrogate family setting. The goal is to support the member and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the member, there is regular contact with the family to prepare for the member's return and his or her ongoing needs as part of the family. It is expected that the member, family, and the professional resource family are integral members of the member's individual treatment team.

Transportation is provided between the member's place of residence and other services sites and places in the community and the cost of transportation is included in the rate paid to providers of this services.

Professional Resource Family Care can be provided anywhere in the community that is agreeable to the individual. Professional Resource Family Care may not be provided simultaneously with Short-Term Respite Care and does not duplicate any other Medicaid state plan service or service otherwise available to members at no cost.

### Admission Criteria

- 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 waiver member's medical record.
- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.

### Service Delivery

- The goal is to support the waiver member and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time.
- During the time the professional resource family is supporting the waiver member, there is regular contact with the family to prepare for the member's return and his or her ongoing needs as part of the family.
- It is expected that the waiver member, family and the professional resource family are integral members of the member's individual treatment team.
- Transportation is provided between the waiver member's place of residence and other services sites and places in the community, and the cost of transportation is included in the rate paid to providers of this services.
- Limitations include:
  - Professional Resource Family Care may not be provided simultaneously with Short Term Respite Care services. The service being provided at midnight is the service to be billed that day.

- Professional Resource Family Care is not available to members in out of home placement because that service is available through Child Welfare Contractors. It can be provided to members who are in DCF or JJA custody but who are living at home. It may be provided to members in Native American child welfare agencies if the service is not otherwise available.
- Professional Resource Family Care does not duplicate any other Medicaid State Plan service or service otherwise available to the waiver member at no cost.

## PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

**Psychiatric Residential Treatment Facility** PRTF is a sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to child or adolescent members who have significant functional impairments resulting from a behavioral health condition.

PRTF is provided as an alternative to hospitalization. The course of treatment in a PRTF 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.

### **Admission Criteria**

- The member's current signs and symptoms meet criteria for a DSM diagnosis not solely due to Mental Retardation/Developmental Disability (MR/DD) and/or alcohol or drug use.  
AND
- Ambulatory care resources available in the community do not meet the member's treatment needs.  
AND
- There is a substantial risk of harm to self or others, or the member is unable to care for his or her own physical health and safety so as to create a danger to his or her life.  
AND
- The factors that precipitated admission indicate that the member requires assistance with restoring skills and abilities essential to functioning. Examples of functional impairment include:
  - Severely impaired social, familial, academic or occupational functioning which may include excessive use of alcohol or drugs.
  - Severely maladaptive or destructive behaviors in school, home, or placement which may include excessive use of alcohol or drugs.
  - Extreme impulsivity demonstrating limited ability to delay gratification.
  - Sexual acting-out that is harmful to self or others, and/or is age inappropriate.
  - A history of running away which puts the member or others at risk.
 AND
- Proper treatment of the member's behavioral health condition requires PRTF services under the direction of a physician.  
AND
- PRTF services can be reasonably expected to improve the member's condition or prevent further regression so that services will no longer be needed.

### **Continuing Stay Criteria**

- The admission criteria continue to be met and active treatment<sup>vi</sup> is being provided.  
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.

### **Discharge Criteria**

- The member has reached age 22.  
OR
- PRTF goals have been met.

- OR
- PRTF goals have not been met, the member is transferred to another inpatient behavioral health or medical service.
- OR
- PRTF goals have not been met, the member or member's guardian chooses to discontinue services.
- OR
- The member is placed in a correctional facility, or removed from treatment and placed for longer than 72 hours while awaiting a court hearing.
- OR
- The member has run away from the facility and is gone for 7 consecutive calendar days with the facility having no knowledge of when the member may return.
- OR
- The member has died.

### **Service Delivery**

- Evaluation and Treatment Planning
  - At the time of admission the physician in conjunction with the treatment team completes the initial evaluation commensurate with the member's needs and stage of development.
  - In the event that not all information is available at the time of the evaluation, there must be enough information to guide development of an individualized plan of care, and support the need for PRTF.
  - The physician in conjunction with the treatment team completes an individual plan of care no later than 14 days after admission. The plan of care is based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the member's situation and reflects the need for PRTF. The plan of care includes specific treatment objectives, interventions and timeframes designed to:
    - Address the member's specific needs and maximize functioning in activities of daily living, education, and vocational preparation;
    - Provide all medically necessary services;
    - Improve the member's recovery/resiliency;
    - Build upon the strengths and preferences of the member and the member's family;
    - Include weekly family involvement with a focus toward the resident and family's presenting problem(s) with assistance given to identify resources and discover solutions;
    - Include discharge planning upon admission; and
    - Achieve the member's discharge at the earliest possible time.
  - The plan of care is reviewed at least every 30 calendar days to determine that services continue to be required, and so that changes may be made as indicated by the member's response to services.
  - The program provides an effective system for reaching out to members who are not attending, becoming isolated, or who are hospitalized.
  - The program collaborates with other providers and agencies to coordinate services and referrals that support the member's engagement.
- The program provides services under the direction of a physician to include:
  - Therapeutic activities such as individual and group counseling;
  - Educational activities;
  - Training activities;
  - Crisis intervention;
  - Development of community living skills;
  - Family support with the approval of the member;
  - Linkages to community resource;
  - Advocacy;
  - Education on wellness and recovery/resiliency;
  - Development of a social support network;
  - Development of recreational and leisure skills;

- o Medical care and/or therapies.
- Discharge Planning
  - o Discharge planning is initiated as part of the development of the plan of care.
  - o The discharge plan is developed with input and participation of the member, the member's family/guardian, member of the treatment team, the referral source, and other community services.
  - o The discharge plan:
    - Is prepared to ensure the member's seamless transition from PRTF;
    - Identifies the member's current progress in his or her recovery/resiliency or move toward well-being;
    - Identifies the gains achieved in PRTF;
    - Identifies the member's need for support systems or other types of services that will assist in continuing his or her recovery/resiliency, well-being, or community integration;
    - Includes information on the continuity of the member's medications;
    - Includes referral information such as contact name, telephone number, hours, and days of service; and
    - Includes communication of information on options and resources if symptoms recur or additional services are needed.
  - o 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.

## SHORT-TERM RESPITE

**Short Term Respite Care** provides temporary direct care and supervision for the member. The primary purpose is to provide relief to families/caregivers of a member with a serious emotional disturbance.

The service is designed to help meet the needs of the primary caregiver as well as the identified member. Normal activities of daily living are considered content of the service when providing respite care, and these include:

- Support in the home, after school, or at night;
- Transportation to and from school, medical appointments, or other community-based activities;
- Any combination of the above.

Short Term Respite Care can be provided in an individual's home or place of residence or provided in other community settings. Other community settings include:

- Licensed Family Foster Home
- Licensed Crisis House
- Licensed Emergency Shelter
- Out-of-Home Crisis Stabilization House/Unit/Bed.

Short Term Respite care can be provided in a group setting as long as the safety of the waiver member is maintained.

The cost of transportation is included in the rate paid to providers of these services.

### Admission Criteria

- 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.
- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.

### Service Delivery

- Limitations include:

- o Short Term Respite Care may not be provided simultaneously with Professional Resource Family Care services. The service being provided at midnight is the service to be billed that day.
- o Short Term Respite Care is not available to members in foster care because that service is available through child welfare contractors. It can be provided to members who are in DCF or JJA custody who are living at home. It can be provided to members who are in DCF custody but who are living at home.
- o Short Term Respite Care will not duplicate any other Medicaid State Plan service or other services otherwise available to recipient at no cost.

## REFERENCES

State of Kansas, Kansas Department for Aging and Disability Services. (2013). Home and Community Based (HCBS) Serious Emotional Disturbance (SED) Waiver Manual. Retrieved from [http://www.kansasbehavioralhealthservices.org/Document/SED\\_Waiver\\_Manual\\_November\\_2013.pdf](http://www.kansasbehavioralhealthservices.org/Document/SED_Waiver_Manual_November_2013.pdf).

State of Kansas, Kansas Administrative Regulations. (2002). Agency 30, Article 5, Section 58, Definitions. Retrieved from <http://dida.library.ucsf.edu/pdf/bra00a10> .

State of Kansas, Kansas Department for Aging and Disability Services. (2013). Home and Community Based (HCBS) Serious Emotional Disturbance (SED) Waiver Manual. Retrieved from [http://www.kansasbehavioralhealthservices.org/Document/SED\\_Waiver\\_Manual\\_November\\_2013.pdf](http://www.kansasbehavioralhealthservices.org/Document/SED_Waiver_Manual_November_2013.pdf).

Kansas Department for Aging and Disability Services Policy Memo for Operation Community Integration, 3/11/2019.

## REVISION HISTORY

| Date       | Action/Description                                                                                                             |
|------------|--------------------------------------------------------------------------------------------------------------------------------|
| 05/20/2019 | <ul style="list-style-type: none"> <li>• Version 1 OCI services; Version 7 remainder of document (Approved by UMC).</li> </ul> |
| 01/31/2020 | <ul style="list-style-type: none"> <li>• Version 2</li> </ul>                                                                  |

<sup>i</sup> (1) A health intervention that is otherwise a Covered Service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

(A) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary.

(B) "Purpose." The health intervention has the purpose of treating a medical condition.

(C) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph three. For existing interventions, effectiveness shall be determined as provided in paragraph four.

(E) "Value." The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean the lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this definition of medical necessity. Interventions that do not meet this definition of medical necessity may be covered at the choice of United. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

(2) The following definitions shall apply to these terms only as they are used in this subsection;

(A) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(B) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

<sup>ii</sup> A youth who experiences serious emotional disturbance is one who meets the criteria in the three areas defined below:

Age: The youth is under the age of 18 or under the age of 22 and has been receiving services prior to the age of 18 that must be continued for optimal benefit.

Duration and Diagnosis: The youth currently has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the most current DSM.

Disorders include those listed in the most current DSM or the ICD – 9 equivalent with the exception of DSM – IV "V" codes, substance abuse or dependence, and developmental disorders, unless they co-occur with another diagnosable disorder that is accepted within this definition.

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Functional Impairment: The disorder must have resulted in functional impairment, which substantially interferes with or limits the youth's role or functioning in family, school, or community activities.

Functional impairment is defined as difficulties (internalizing and externalizing) that substantially interferes with or limits a youth from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included.

Youth that would have met functional impairment criteria without the benefit of treatment or other support services are included in this definition.

Which of the following functional areas has been disrupted as a direct result of the child's mental health condition? (Examples are not intended to be all-inclusive, and more than one can be marked).

School (for example: in-school suspension, out-of-school suspension, withdrawn at school to the point that performance is impacted).

Family (for example: at-risk of out-of-home placement, physical aggression at home, suicidal).

Community (for example: law enforcement contact, unable to or serious difficulty participating in extracurricular activities due to behavior or isolating from peers).

All SED waiver members must meet minimum scores on the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist (CBCL). The minimum total score for the CAFAS is 100, or 30 on any two subscales. The minimum score for the CBCL is a t-score of 70 on any of the 3 subscales.

Exclusions: Functional Impairment does not qualify if it is a temporary response to stressful events in the youth's environment.

Functional impairment also does not qualify if it can be attributed solely to intellectual, physical, or sensory deficits.

<sup>ii</sup> The member has one of the following conditions:

Category A Diagnoses

- Bipolar I Disorders that are Severe and/or with Psychotic Features
- Major Depressive Disorder, Recurrent, Severe with Psychotic Features
- Psychotic Disorder NOS
- Schizoaffective Disorder
- Schizophrenia, Catatonic Type
- Schizophrenia, Disorganized Type
- Schizophrenia, Paranoid Type
- Schizophrenia, Residual Type
- Schizophrenia, Undifferentiated Type

Category B Diagnoses

- All other Bipolar I Disorders not listed in Category A
- Bipolar II Disorder
- Borderline Personality Disorder
- Delusional Disorder
- Major Depressive Disorder, Recurrent, In Full Remission
- Major Depressive Disorder, Recurrent, In Partial Remission
- Major Depressive Disorder, Recurrent, Moderate
- Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
- Major Depressive Disorder, Single Episode, With Psychotic Features
- Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
- Obsessive Compulsive Disorder
- Panic Disorder with Agoraphobia

An adult with a Category A diagnosis must evidence impaired functioning by meeting at least 1 of the following criteria:

- Required inpatient hospitalization for psychiatric care and treatment more intensive than outpatient care at least once in his/her lifetime;
- Experienced at least one episode of disability requiring continuous, structured supportive residential care, lasting for at least 2 months (e.g., nursing facility, group home, half-way house, residential mental health treatment in a state correctional facility); or
- Experienced at least one episode of disability requiring continuous, structured supportive care, lasting at least 2 months, where the family, significant other or friend of the member provided this level of care in lieu of the member entering formalized institutional services.
- An adult with a Category A diagnosis must also evidence impaired functioning by meeting at least 3 of the following criteria:
  - The member has been unemployed, employed in a sheltered setting, or has markedly limited skills and a poor work history;
  - The member has required public financial assistance for their out-of-institutional maintenance and is unable to procure such financial assistance without help;
  - The member shows severe inability to establish or maintain a personal support system, evidenced by extreme withdrawal and social isolation;
  - The member requires help in instrumental activities of daily living such as shopping, meal preparation, laundry, basic housekeeping, and money management;
  - The member requires help in attending to basic health care regarding hygiene, grooming, nutrition, medical and dental care, and taking medications; or
  - The member exhibits inappropriate social behavior not easily tolerated in the community, which results in demand for intervention by the mental health or judicial system (e.g., screaming, self-abusive acts, inappropriate sexual behavior, verbal harassment of others, or physical violence toward others).
- An adult with a Category B diagnosis must meet the above functional impairment criteria, and score at least 10 on the risk assessment.

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<sup>iii</sup> Disorders include those listed in the DSM or ICD-9 equivalent with the exception of the DSM "V" codes, substance abuse or dependence, anti-social personality disorder, disorders due to a general medical condition, substance induced psychiatric disorders, and developmental disorders, unless they co-occur with another diagnosable disorder that is accepted within this definition.

<sup>iv</sup> Impaired functioning is evidenced by the following that have occurred as either a continuous or intermittent basis over the last two years and are as a direct result of the individual's mental illness:

- a. The member has been unemployed, employed in a supported setting, or has markedly limited skills and a poor work history and/or unable to attend school;
- b. The member requires public financial assistance for their out-of-institutional maintenance and is unable to procure such financial assistance without help;
- c. The member shows severe inability to establish or maintain a personal support system, evidenced by extreme withdrawal and isolation;
- d. The member requires help in instrumental activities of daily living such as shopping, meal preparation, laundry, basic housekeeping and money management;
- e. The member requires help in attending to basic health care regarding hygiene, grooming, nutrition, medical and dental care and taking medications. (Note: this refers to the lack of a basic skill to accomplish the task, not to the appropriateness of their dress, meal choices, or personal hygiene);
- f. The member exhibits inappropriate social behavior not easily tolerated in the community, which results in demand for intervention by the mental health or judicial systems (e.g. screaming, self-abusive acts, inappropriate sexual behavior, verbal harassment of others, physical violence toward others);
- g. The member has at least one psychiatric hospitalization within the last 2 years.

<sup>v</sup> "Medical Necessity" means the clinical intervention for an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

- a. Authority. The clinical intervention is recommended by the treating clinician and is determined to be necessary by the Secretary or the Secretary's designee.
- b. Purpose. The clinical intervention has the purpose of treating a medical condition/mental illness.
- c. Scope. The clinical intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the Member.
- d. Evidence. The clinical intervention is known to be effective in improving health outcomes. The scientific evidence for each existing intervention shall be considered first and, to the extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.
- e. Value: The clinical intervention is cost-effective for this condition compared to alternative interventions, including no intervention. The term "cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be clinically indicated and yet not be a covered benefit or meet the definition of medical necessity. Interventions that do not meet the definition of medical necessity may be covered at the choice of the Secretary or the Secretary's designee. An intervention shall be considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for Members with this condition. In the application of this criterion to an individual case, the characteristics of the individual Member shall be determinative. "Medical necessity in psychiatric situations" means that there is medical documentation that indicates that the person could be harmful to him or herself or others if not under psychiatric treatment or that the person is disoriented in time, place, or person.
- f. The clinical intervention is not solely for the convenience of the Member, the Member's family, or the Provider.

<sup>vi</sup> "Active treatment means the implementation and supporting documentation of services outlined in a plan of care developed by a treatment team facilitated by the PRTF. It includes assessment, treatment, crisis prevention and discharge planning. Treatment, overseen by a physician, is designed to achieve the goal of the member's successful transition back to the community at the earliest possible time. Treatment reviews address and encourage the therapeutic alliance, collaboration on tasks and consensus on goals from staff, the member, the member's family, and community partners.