United Behavioral Health

Level of Care Guidelines: Allways Plan of Massachusetts (Medicaid)

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INTRODUCTION

The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support recovery, resiliency, and well-being.
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®. 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 information collected by the provider following evaluation and treatment planning described in Clinical Best Practices.

AND

- The member’s condition can be safely, effectively, and efficiently 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.
  - Medically Necessary or Medical Necessity – in accordance with 130 CMR 450.204, Medically Necessary services are those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.
    - For adults, services are medically necessary if:
      - The service is reasonably calculated to prevent, diagnose, or treat conditions that endanger life, cause pain or cause functionally significant deformity or malfunction;

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

2 MA Medicaid Contract definition of Medical Necessity
There is no other equally effective course of treatment available or suitable for the member which is more conservative or substantially less costly;

Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available upon request.

For children and adolescents, services are medically necessary if:

- The service is necessary to correct or ameliorate defects or mental health conditions, and are not covered for cosmetic, convenience, or comfort reasons;
- The service is required as defined in Section 1905r of the Social Security Act;
- The service is safe and effective;
- There is no other equally effective course of treatment available or suitable for the member which is more conservative or substantially less costly;
- The service is substantiated by records including evidence of such medical necessity and quality as documented by the attending provider. Those records must be made available upon request.

AND

In addition to the above, adult and member services must also meet acceptable national standards of medical practice.

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 functioning.

- 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 discontinue 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.

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.

**Applied Behavior Analysis (ABA)** is a service that provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with the member’s successful functioning. ABA includes services provided by two different sets of credentials; Licensed Applied Behavior Analyst and behavior technician/paraprofessional. It is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff. Phone contact and consultation may be provided as part of the intervention.

**Center-Based Applied Behavior Analysis** serves members under the age of 21 to provide clarification related to the delivery of Applied Behavior Analysis (ABA) services in a center-based setting. The efficacy of providing ABA services in the home allows for the child’s generalization of skills through an individualized treatment plan and targeting maladaptive behaviors, if any. It also allows for adequate parent training and observation. However, in certain instances, center-based services may also be authorized. Services that are primarily for school and educational purposes are excluded and will not be covered under center based services. Center based services must be medically necessary; center based service delivery that is solely for the convenience of the parent or family are also excluded.

ABA Providers include:

- **Licensed Applied Behavior Analyst**: This service includes a behavioral assessment (including observing the member’s behavior, antecedents of behaviors, and identification of motivators); development of a highly specific behavior treatment plan; supervision and coordination of interventions; and training other interveners to address specific behavioral objectives or performance goals. This service is designed to treat challenging behaviors that interfere with the child/member’s successful functioning. The Licensed Applied Behavior Analyst develops specific behavioral objectives and interventions that are designed to develop adaptive skills and diminish, extinguish, or improve specific behaviors related to the member’s behavioral health condition(s) and which are incorporated into the behavior management treatment plan and the risk management/safety plan.

- **Behavior Technician/Paraprofessional**: This service includes implementation of the treatment plan, monitoring the member’s behavior, reinforcing implementation of the treatment plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the Licensed Applied Behavior Analyst on implementation of the treatment plan and progress toward behavioral objectives or performance goals.

**Admission Criteria**

- See Common Criteria

- The intervention is a systematic approach, based on the principles of comprehensive applied behavior analysis
- The intervention targets the core deficits of an autism spectrum disorder, as outlined by the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5®)
- The intervention is delivered in a home or community setting
- The intervention is rendered directly by a Board-certified Behavior Analyst (BCBA), a licensed mental health clinician with additional documented training in applied behavior analysis, or a paraprofessional under the direct supervision of such professionals
- The intervention is delivered with an appropriate level of intensity (e.g., per Behavior Analyst Certification Board® practice guidelines) and includes ongoing measurement of efficacy: the use of measurement tools and analysis of progress should be continuous, and treatment decisions based on objective analysis of assessment results.

**Continuing Stay Criteria**

- See Common Criteria
AND

- With each medical necessity review for continued ABA treatment, an updated treatment plan and progress reports will be required for review, including all of the following documentation:
  - There is a reasonable expectation on the part of the treating clinician that the child’s behavior and skill deficits will continue to improve to a clinically meaningful extent, in at least two settings (home, school, community) with ABA services
  - Therapy is not making the symptoms or behaviors persistently worse
  - Progress is assessed and documented for each targeted symptom and behavior, including progress toward defined goals, and including the same modes of measurement that were utilized for baseline measurements of specific symptoms and behaviors.
  - The treatment plan and progress report should reflect improvement from baseline in skill deficits and problematic behaviors using validated assessments of adaptive functioning.
  - When there has been inadequate progress with targeted symptoms or behaviors, or no demonstrable progress within a six month period, or specific goals have not been achieved within the estimated timeframes, there should be an assessment of the reasons for inadequate progress or not meeting the goals, and treatment interventions should be modified or changed in order to attempt to achieve adequate progress.

- Documentation of such an assessment and subsequent treatment plan change(s) must include:
  - Increased time and/or frequency working on targets
  - Change in treatment techniques
  - Increased parent/caregiver training
  - Identification and resolution of barriers to treatment effectiveness
  - Any newly identified co-existing disorder (e.g., anxiety, psychotic disorder, mood disorder)
  - Goals reconsidered (e.g., modified or removed)

- When goals have been achieved, either new goals should be identified that are based on targeted symptoms and behaviors that are preventing the child from adequately participating in age-appropriate home, school or community activities, or that are presenting a safety risk to self, others, or property; or, the treatment plan should be revised to include a transition to less intensive interventions.

**Discharge Criteria**

- See Common Criteria

AND

- When any of the following criteria are met the child will be considered discharged and any further ABA services will be considered not medically necessary
  - Documentation that the child demonstrates improvement from baseline in targeted skill deficits and behaviors to the extent that goals are achieved or maximum benefit has been reached
  - Documentation that there has been no clinically significant progress or measurable improvement for a period of at least 3 months in the child’s behaviors or skill deficits in any of the following measures:
    - Adaptive functioning
    - Communication skills
    - Language skills
    - Social skills
  - The treatment is making the skill deficits and/or behaviors persistently worse
  - The child is unlikely to continue to benefit or maintain long term gains from continued ABA therapy
  - Parents and/or caregivers have refused treatment recommendations or are unable to participate in the treatment program and/or do not follow through on treatment recommendations to an extent that compromises the effectiveness of the services.

**Clinical Best Practices**

- See Common Clinical Best Practices
AND

- The ABA provider works closely with the family and any existing providers (i.e., behavioral health, physical health, local education authority) to implement the goals and objectives.
- The ABA provider participates in coordination of care with agencies with regard to service/care planning and coordination, on behalf of, and with, the family.

Licensed Applied Behavior Analyst Responsibilities

- The Functional Behavioral Assessment is conducted and includes descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. In certain instances in which a severe behavior is present, this may also involve a functional analysis for safe testing in a controlled environment.
- Documents observations of the member in the home and community
- Designs and supervises behavior analytic interventions
- Conducts structured interviews with the member, family, and any identified collaterals about his or her behavior(s)
- Completes of a written functional behavioral assessment
- Develops a focused treatment plan that identifies specific and measurable objectives or performance goals and interventions (e.g., skills training, reinforcement systems, removal of triggering stimuli, graduated exposure to triggering stimuli, etc.) that are designed to diminish, extinguish, or improve specific behaviors related to a member’s mental health condition(s)
- Develops specific objectives and interventions that are incorporated into the member’s new or existing risk management/safety plan
- Parent training must occur and include at least 2 specific and measurable parent/guardian/caregiver treatment goals and provides instruction for the parent/guardian/caregiver on how to implement strategies identified in the behavior management plan
- Works closely with the behavior technician/paraprofessional to ensure the treatment plans and risk management/safety plan are implemented as developed and to make any necessary adjustments to the plan
- Supervises the work of those who implement behavior analytic interventions including the Behavior Technicians/Paraprofessionals.

Evaluation and Treatment Planning

- Once an initial authorization is approved, the provider will, within ten business days, offer a face-to-face interview with the family to occur within 14 days.
- ABA services are provided in a clinically appropriate manner and focused on behavioral and functional outcomes as described in the treatment and discharge plans.
- The Licensed Applied Behavior Analyst completes a written functional behavioral assessment and develops a highly specific treatment plan with clearly defined interventions and measurable goals and outcomes that are consistent with the concerns and goals identified by the referring provider and family.
- When requesting services the provider should coordinate the treatment plan with the member’s Individualized Education Program/Individualized Family Service Plan as appropriate and, with appropriate consent/authorization, submits the IEP/IFSP.
- The treatment plan is individualized. Objectives are measurable and tailored to the individual.
- Interventions emphasize the elimination of risk-related behaviors and generalization of skill and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors and include a focus that:
  - targets specific behaviors (including frequency, rate, symptom intensity, duration);
incorporates objective baseline and quantifiable progress measures; and
describe detailed behavioral interventions, reinforcers, and strategies for
generalization of skills beyond the ABA sessions.

- Specific and measurable Parent/caregiver goals for training and support are included in the
treatment plan with documented plans that skills transfer to the parent/caregiver will occur.
- The treatment plan should address some of the following domains as appropriate for the child:
cognitive functioning, safety skills, social skills, play and leisure skills, community integration,
vocational skills, coping and tolerance skills, adaptive and self-help skills, language and
communication, attending and social referencing, and reduction of interfering or inappropriate
behaviors.
- For social skills group, delivered by a Licensed Professional including Behavior Analyst, Social
Worker, Psychologist, Marriage and Family Therapist or Mental Health Counselor develops a
structured social skills behavior plan which addresses individual needs, documents the
curriculum being used and maintains treatment notes that indicates progress for that
individual in a group setting.
- There is documented active coordination of care with ICC, other current behavioral health
providers, the primary care physician/clinician (PCP/PCC), and other services and state
agencies. If coordination is not successful, the reasons are documented, and efforts to
coordinate care continue.
- If the member requires ongoing ABA, in concert with the family, the Licensed Applied Behavior
Analyst will determine if the member needs ABA.
- The ABA provider ensures that all services are provided in a professional manner, ensuring
privacy, safety, and respecting the family’s dignity and right of choice.
- The Licensed Applied Behavior Analyst and behavioral technician/paraprofessional document
each contact in a progress report or notes in the provider’s file for the member.
- The Licensed Applied Behavior Analyst gives his or her agency’s after-hours emergency
contact information and procedures to the parent/guardian/caregiver.

Discharge Planning and Documentation

- A discharge planning meeting is scheduled when services are no longer desired and, along
with the family, the provider determines that the member has met his or her goals and no
longer needs the service, or the member no longer meets the medical necessity criteria for
ABA therapy.
- There is documented active discharge planning from the beginning of treatment.
- The reasons for discharge and all behavior management treatment and discharge plans are
clearly documented in the record.
- The Licensed Applied Behavior Analyst staff develops an up-to-date copy of the treatment plan,
which is given to the parent/guardian/caregiver on the last date of service and to all current
providers within seven days of the last date of service.
- If an unplanned termination of services occurs, the provider makes every effort to contact the
parent/guardian/caregiver to obtain their participation in ABA and to provide assistance for
appropriate follow-up plans (i.e., schedule another appointment, facilitate a clinically
appropriate service termination, or provide appropriate referrals). Such activity is
documented in the record.

Exclusions/Limitations

- Staff Meetings/ Professional Development/ Staff Trainings
- This also includes members of the same organization meeting to discuss a client without the
member present
- Completion of Agency-Related Administrative Documentation
- e.g. Travel Vouchers, Time sheets and billing logs
- Breaks (including lunch)
- Checking member eligibility
- Time spent completing authorization/review
- Report Writing
- Travel
- Development of visual aids, social stories and other tools except when created with the child/caretaker(s).

### CHILDERN'S BEHAVIORAL HEALTH INITIATIVE SERVICES (CBHI)

#### CBHI

- **In-Home Behavioral Services**: IHBS services is a combination of Behavior Management Therapy and Behavior Management Monitoring and such services are provided where the member resides, including in the member’s home, a foster home, a therapeutic foster home or another community setting.

- **Behavior Management Therapy**: Addresses challenging behaviors that interfere with a member’s successful functioning. Services include assessment, development of a behavior plan and supervision and coordination of interventions to address specific behavioral objectives. Development of a crisis-response strategy and short-term counseling and assistance may also be provided.

- **Behavior Management Monitoring**: Is the monitoring of a member’s behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the member’s parent or other caregiver.

  *For member engaged in Intensive Care Coordination (ICC), the Behavior Plan is designed to achieve a goal(s) identified in the member’s Individual Care Plan (ICP). The Care Planning Team (CPT) works closely with the member, parent/guardian/caregiver and/or other individual(s) identified by the family to support adherence to the behavior plan and to sustain the gains made.*

#### Admission Criteria

- See Common Criteria
  
  AND

- A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (MA CANS) indicates that the member’s clinical condition warrants this service in order to diminish, extinguish, or improve specific behaviors related to the member’s behavioral health condition(s).

- Alternative behavioral health interventions have not been successful in reducing or eliminating the problem behaviors or increasing/maintaining desirable behaviors.

- A clinical evaluation suggest that the member’s clinical condition, level of functioning, and intensity of need require the structure and positive behavioral supports to be applied consistently across home and school settings and warrant this level of care to successfully support the member in the home and community.

- The member is currently engaged in outpatient services, In-Home Therapy, or ICC, and the provider or ICC determine that In-Home Behavioral Services are needed in order to facilitate the attainment of a goal or objective identified in the treatment plan or ICP that address specific behavioral objectives or performance goals designed to treat challenging behaviors that interfere with the member’s successful functioning.

#### Continuing Stay Criteria
• See Common Criteria
  AND
• The member’s clinical condition(s) continues to warrant In-Home Behavioral Services in order to maintain him/her in the community and continue progress toward goals established in the behavior plan.
• The member is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition.
• With consent, the parent/guardian/caregiver, and/or natural supports are actively involved in the treatment as required by the behavior plan, or there are active efforts being made and documented to involve them.

**Discharge Criteria**

• See Common Criteria
  AND
• The member no longer meets admission criteria for this level of care, or meets criteria for a less or more intensive level of care.
• The member’s behavior plan goals and objectives have been substantially met, and continued services are not necessary to prevent the worsening of the member’s behavior.
• The member and/or parent/guardian/caregiver are not engaged in treatment. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues.
• The member is not making progress toward goals and objectives in the behavior plan, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.
• Consent for treatment is withdrawn.

**Clinical Best Practices**

• See Common Clinical Best Practices
  AND
• Evaluation and service planning is member and family centered.
• The member and family/caregivers are actively being engaged in services.
• The provider helps the member and family/caregivers:
  o Identify the goals of the member and family throughout the treatment process;
  o Monitor the progress of the member toward achievement of the goals; and
  o Monitor the progress of the family toward achievement of the goals.
• The provider collaborates with other programs in planning service delivery.

**Exclusions/Limitations**

• The environment in which the service takes place presents a serious safety risk to the behavior management therapist or monitor, alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service.
• The member is at imminent risk to harm self or others, or sufficient impairment exists that requires a more-intensive level of care beyond a community-based intervention.
• The member has medical conditions or impairments that would prevent beneficial utilization of services.
• Introduction of this service would be duplicative of services that are already in place.
The member is in a hospital, skilled nursing facility psychiatric residential treatment facility, or other residential setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports.

**COMMUNITY-BASED ACUTE TREATMENT FOR CHILDREN AND ADOLESCENTS (CBAT)**

**Community-Based Acute Treatment for Children and Adolescents (CBAT)** Mental health services provided in a secure 24-hour setting with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specializing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services.

Active family/caregiver involvement through family therapy, a key element of treatment, is expected. Discharge planning should begin at admission, including plans for reintegration into the home, school, and community. If discharge to home/family is not an option, alternative placement must be rapidly identified with regular documentation of active efforts to secure such placement.

**Admission Criteria**
- See Common Criteria
- The member demonstrates symptomatology consistent with a DSM-5 diagnosis, which requires and can reasonably be expected to respond to therapeutic intervention;
- The member is experiencing emotional or behavioral problems in the home, school, community, and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured, 24-hour therapeutic environment;
- The member has only poor or fair motivation and/or insight and the community supports are inadequate to support recovery;
- The family situation and functioning levels are such that the member cannot currently remain in the home environment and receive outpatient treatment; and
- The member has sufficient cognitive capacity to respond to active and time limited psychological treatment and interventions.

**Continuing Stay Criteria**
- See Common Criteria
- The member’s condition continues to meet admission criteria at this level of care;
- The member’s treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate;
- Treatment planning is individualized and appropriate to the member’s age and changing condition, with realistic, specific, and attainable goals and objectives stated;
  - Treatment planning includes family, support systems, social, educational, occupational, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all relevant treatment modalities is documented. The treatment plan has been updated and implemented with consideration of all applicable and appropriate treatment modalities.
- All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;
- If treatment progress is not evident, then there is documentation of treatment plan adjustments to address the lack of progress;
• Care is rendered in a clinically appropriate manner and focused on the member’s behavioral and functional outcomes;

• An individualized discharge plan has been developed that includes specific realistic, objective, and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place, but discharge criteria have not yet been met;

• The member is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the member’s engagement in treatment, improve functionality and reduce acute psychiatric/behavioral symptoms;

• Unless contraindicated, family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them;

• When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated; and

• There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.

Discharge Criteria

• See Common Criteria

AND

• The member can be safely treated at an alternative level of care; and

• An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place.

• One of the following criteria is also necessary for discharge from this level of care:
  
  o The member no longer meets admission criteria or meets criteria for a less or more intensive level of care;
  
  o The member’s documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at an alternate level of care;
  
  o The member, parent, and/or legal guardian is competent but not engaged in treatment or is not following the program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. In addition, it has been determined that the member does not meet criteria for an inpatient level of care;
  
  o Consent for treatment is withdrawn, and it is determined that the member or parent/guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care;
  
  o The member is not making progress toward treatment goals despite persistent efforts to engage him/her, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of function; or
  
  o The member’s physical condition necessitates transfer to a medical facility.

Clinical Best Practices

• See Common Clinical Best Practices

Exclusions/Limitations
• The member exhibits severe suicidal, homicidal, or acute mood symptoms/thought disorder, which require a more intensive level of care;
• The parent/guardian does not voluntarily consent to admission or treatment;
• After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5 diagnosis, which is amenable to continued treatment at this level of care. Conditions that would not be appropriate for continued treatment are:
  o permanent cognitive dysfunction without an acute psychiatric disorder
  o primary substance use disorder requiring treatment in a specialized level of care
  o medical illness requiring treatment in a medical setting
  o impairments indicate no reasonable expectation of progress toward treatment goals at this level of care
  o chronic condition with no indication of need for ongoing treatment at this level of care to maintain stability and functioning
• The member can be safely maintained and effectively treated at a less intensive level of care;
• The member has medical conditions or cognitive or psychiatric impairments that would prevent beneficial utilization of services;
• The primary problem is not psychiatric. It is a social, legal, or medical problem, without a concurrent major psychiatric episode meeting criteria for this level of care; or
• The admission is being used as an alternative to placement within the juvenile justice or protective services system, or as an alternative to specialized schooling (which should be provided by the local school system) or as respite or housing.

Family Support and Training

A service provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child’s emotional or behavioral needs and to parent; provided, however, that such service shall be provided where the child resides, including in the child’s home, a foster home, a therapeutic foster home or another community setting.

Services may include education, assistance in navigating the child serving systems (DCF, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.); and support, coaching, and training for the parent/caregiver.

Admission Criteria

• See Common Criteria
  AND
• A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (CANS) indicates that the member’s clinical condition warrants this service in order to improve the capacity of the parent/caregiver to ameliorate or resolving the member’s emotional or behavioral needs and strengthen the parent/caregiver’s capacity to parent so as to successfully support the member in the home or community setting.
• The parent/caregiver requires education, support, coaching, and guidance to improve their capacity to parent in order to ameliorate or resolve the member’s emotional or behavioral needs so as to improve the member’s functioning as identified in the outpatient or In-Home Therapy treatment plan/ICP, for those member enrolled in ICC, and to support the member in the community.
• Outpatient services alone are not sufficient to meet the parent/caregiver’s needs for coaching, support, and education.
• The parent/caregiver gives consent and agrees to participate.
- A goal identified in the member’s outpatient or In-Home Therapy treatment plan or ICP, for those enrolled in ICC, with objective outcome measures pertains to the development of the parent/caregiver capacity to parent the member in the home or community.
- The member resides with or has current plan to return to the identified parent/caregiver.

**Continuing Stay Criteria**
- See Common Criteria
  AND
- The parent/caregiver continues to need support to improve his/her capacity to parent in order to ameliorate or resolve the member’s emotional or behavioral needs as identified in the outpatient or In-Home Therapy treatment plan/ICP, for those member enrolled in ICC, and to support the member in the community.
- Care is rendered in a clinically appropriate manner and focused on the parent/caregiver’s need for support, guidance, and coaching.
- All services and supports are structured to achieve goals in the most time efficient manner possible.
- For members in ICC, with required consent, informal and formal supports of the parent/caregiver are actively involved on the member’s team.
- With required consent, there is evidence of active coordination of care with the member’s care coordinator (if involved in ICC) and/or other services and state agencies.
- Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the treatment plan/ICP to address lack of progress are evident.

**Discharge Criteria**
- See Common Criteria
  AND
- The parent/caregiver no longer needs this level of one-to-one support and is actively utilizing other formal and/or informal support networks.
- The member’s treatment plan/ICP indicates the goals and objectives for Family Support and Training have been substantially met.
- The parent/caregiver is not engaged in the service. The lack of engagement is of such a degree that this type of support becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues.
- The parent/guardian/caregiver withdraws consent for treatment.

**Clinical Best Practices**
- See Common Clinical Best Practices

**Exclusions/Limitations**
- There is impairment with no reasonable expectation of progress toward identified treatment goals for this service.
- There is no indication of need for this service to ameliorate or resolve the member’s emotional needs or to support the member in the community.
- The environment in which the service takes place presents a serious safety risk to the Family Support and Training Partner making visits, alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service.
- The member is placed in a residential treatment setting with no current plans to return to the home setting.
- The member is in an independent living situation and is not in the family’s home or returning to a family setting.
- The service needs identified in the treatment plan/ICP are being fully met by similar services from the same or any other agency.

**TARGETED CASE MANAGEMENT: INTENSIVE CARE COORDINATION**

**Intensive Care Coordination** A wraparound service that facilitates care planning and coordination of services to children and adolescents under the age of 21 with a serious emotional disturbance, including individuals with co-occurring conditions. This service includes assessment, development of an individualized care plan, referral and related activities to implement the care plan, and monitoring of the care plan.

ICC provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/member-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the member, are developed through a Wraparound planning process that results in an individualized plan of care for the member and family. ICC is designed to facilitate a collaborative relationship among a member with SED, his/her family and involved child-serving systems to support the parent/caregiver in meeting their member’s needs. The ICC care planning process ensures that a Care Coordinator organizes and matches care across providers and child serving systems to enable the member to be served in his/her home community.

**Admission Criteria**

- See Common Criteria
  AND
- The member meets the criteria for serious emotional disturbance (SED) as defined by either Part I or II of the criteria below.

**Part I:**
- The member currently has, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD-10 or DSM-5 of the American Psychiatric Association, with the exception of other V codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.
- The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the member’s role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the member in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.
- Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.
- Member who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

**OR**

**Part II:**
- The member exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and
teachers; inappropriate types of behavior or feelings under normal circumstances; a
general pervasive mood of unhappiness or depression; or a tendency to develop
physical symptoms or fears associated with personal or school problems.

- The emotional impairment is not solely the result of autism, developmental delay,
  intellectual impairment, hearing impairment, vision impairment, deaf-blind
  impairment, specific learning disability, traumatic brain injury, speech or language
  impairment, health impairment, or a combination thereof.

- The member:
  - Needs or receives multiple services other than ICC from the same or multiple
    provider(s) OR
  - Needs or receives services from, state agencies, special education, or a
    combination thereof; AND
  - Needs a care planning team to coordinate services the member needs from
    multiple providers or state agencies, special education, or a combination
    thereof.

- The person(s) with authority to consent to medical treatment for the member voluntarily
  agrees to participate in ICC. The assent of a member who is not authorized under applicable
  law to consent to medical treatment is desirable but not required.

- For member in a hospital, skilled nursing facility, psychiatric residential treatment facility or
  other residential treatment setting who meet the above criteria, the admission to ICC may
  occur no more than 180 days prior to discharge from the above settings.

**Continuing Stay Criteria**

- See Common Criteria
  AND
- The member’s clinical condition(s) continues to warrant ICC services in order to coordinate the
  member’s involvement with state agencies and special education or multiple service providers.
- Progress toward Individualized Care Plan (ICP)-identified goals is evident and has been
  documented based upon the objectives defined for each goal, but the goals have not yet been
  substantially achieved despite sound clinical practice consistent with Wraparound and Systems
  of Care principles; OR
- Progress has not been made, and the Care Plan Team (CPT) has identified and implemented
  changes and revisions to the ICP to support the goals of the member and family.

**Discharge Criteria**

- See Common Criteria
  AND
- The member no longer meets the criteria for SED.
- The CPT determines that the member’s documented ICP goals and objectives have been
  substantially met, and continued services are not necessary to prevent worsening of the
  member’s behavioral health condition.
- Consent for treatment is withdrawn.
- The member and parent/caregiver are not engaged in treatment. Despite multiple,
  documented attempts to address engagement, the lack of engagement is to such a degree
  that it implies withdrawn consent or treatment at this level of care becomes ineffective or
  unsafe.
- The member is placed in a hospital, skilled nursing facility, psychiatric residential treatment
  facility, or other residential treatment setting and is unable to return to a family home
  environment or a community setting with community-based supports or ICC.
• The member turns 21.

Clinical Best Practices

• See Common Clinical Best Practices

AND

• The Care Coordinator facilitates the development of a Care Planning Team (CPT) comprised of both formal and natural support persons who assist the family in identifying goals and developing an Individual Care Plan (ICP) and risk management/safety plan; convenes CPT meetings; coordinates and communicates with the members of the CPT to ensure the implementation of the ICP; works directly with the member and family to implement elements of the ICP; coordinates the delivery of available services; and monitors and reviews progress toward ICP goals and updates the ICP in concert with the CPT. The provision of ICC services reflects the individualized needs of member and their families. Changes in the intensity of a member’s needs over time should not result in a change in Care Coordinator.

• Delivery of ICC may require Care Coordinators to team with Family Partners. In ICC, the Care Coordinator and Family Partner work together with member with SED and their families while maintaining their discrete functions. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/caregiver(s) in articulating the member’s strengths, needs, and goals for ICC to the Care Coordinator and CPT. The Family Partner educates parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them and facilitates the caregiver’s access to these resources.

Assessment: The Care Coordinator facilitates the development of the Care Planning Team (CPT), who utilize multiple tools, including a strength-based assessment inclusive of the Child and Adolescent Needs and Strengths (MA CANS version), in conjunction with a comprehensive assessment and other clinical information to organize and guide the development of an Individual Care Plan (ICP) and a risk management/safety plan. The CPT is a source for information needed to form a complete assessment of the member and family. The CPT includes, as appropriate, both formal supports, such as the Care Coordinator, providers, Case Managers from child-serving state agencies, and natural supports, such as family members, neighbors, friends, and clergy. Care Coordinator assessment activities include without limitation:

  o Assisting the family to identify appropriate members of the CPT;

  o Facilitating the CPT to identify strengths and needs of the member and family in meeting their needs; and

  o Collecting background information and plans from other agencies.

• The assessment process determines the needs of the member for any medical, educational, social, therapeutic, or other services. Further assessments will be provided as medically necessary.

Development of an Individual Care Plan: Using the information collected through an assessment, the Care Coordinator convenes and facilitates the CPT meetings, and the CPT develops a child- and family-centered Individual Care Plan (ICP) that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the member and family. The Care Coordinator works directly with the member, the family (or the authorized health care decision maker), and others to identify strengths and needs of the member and family and to develop a plan for meeting those needs and goals with concrete interventions and strategies, and identified responsible persons.

• Referral and related activities: Using the ICP, the Care Coordinator:

  o Convenes the CPT which develops the ICP;

  o Works directly with the member and family to implement elements of the ICP;
- Prepares, monitors, and modifies the ICP in concert with the CPT;
- Will identify, actively assist the member and family to obtain and monitor the delivery of available services including medical, educational, social, therapeutic, or other services;
- Develops with the CPT a transition plan when the member has achieved goals of the ICP; and,
- Collaborates with the other service providers and state agencies (if involved) on the behalf of the member and family.

**Monitoring and follow-up activities:** The Care Coordinator will facilitate reviews of the ICP, convening the CPT as needed to update the plan of care to reflect the changing needs of the member and family. The Care Coordinator working with the CPT perform such reviews and include:

- Whether services are being provided in accordance with the ICP;
- Whether services in the ICP are adequate; and
- Whether these are changes in the needs or status of the member and if so, adjusting the plan of care as necessary.

**Exclusions/Limitations**

- The person(s) with authority to consent to medical treatment for the member does not voluntarily consent to participate in ICC.
- The member is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is unable to return to a family home environment or community setting with community-based supports.

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**IN-HOME THERAPY**

This service is delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary In-Home Therapy and Therapeutic Training and Support. The main focus of IHT Services is to ameliorate the member's mental health issues and strengthen the family structures and supports. IHT Services are distinguished from traditional therapy in that services are delivered in the home and community; services include 24/7 urgent response capability on the part of the provider; the frequency and duration of a given session matches need and is not time limited; scheduling is flexible; and services are expected to include the identification of natural supports and include coordination of care.

Interventions are designed to enhance and improve the family's capacity to improve the member's functioning in the home and community and may prevent the need for the member's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting.

In-Home Therapy is provided by a qualified clinician who may work in a team that includes one or more qualified paraprofessionals.

**Admission Criteria**

- See Common Criteria
  AND
- A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (MA CANS) indicates that the member’s clinical condition warrants this service in order to enhance problem-solving, limit-setting, and risk management/safety planning and communication; to advance therapeutic goals or improve ineffective patterns of interaction; and to build skills to strengthen the parent/caregiver's ability to sustain the member in their home setting or to prevent the need for more-intensive levels of service such as inpatient hospitalization or other out-of-home behavioral health treatment services.
- The member resides in a family home environment (e.g., foster, adoptive, birth, kinship)
and has a parent/guardian/caregiver who voluntarily agrees to participate in In-Home Therapy Services.

- Outpatient services alone are not or would not likely be sufficient to meet the member and family’s needs for clinical intervention/treatment.
- Required consent is obtained.

**Continued Service Criteria**

- See Common Criteria and Best Practices for All Levels of Care
  AND
- The member’s clinical condition continues to warrant In-Home Therapy Services, and the member is continuing to progress toward identified, documented treatment plan goal(s).
- Progress toward identified treatment plan goal(s) is evident and has been documented based upon the objectives defined for each goal, but the goal(s) has not been substantially achieved.
  OR
- Progress has not been made, and the In-Home therapy team has identified and implemented changes and revisions to the treatment plan to support the goals.
- The member is actively participating in the treatment as required by the treatment plan/ICP to the extent possible consistent with his/her condition.
- The parent/guardian/caregiver is actively participating in the treatment as required by the treatment plan/ICP.

**Discharge Criteria**

- See Common Criteria and Best Practices for All Levels of Care
  AND
- The member no longer meets admission criteria for this level of care or meets criteria for a less- or more-intensive level of care.
- The treatment plan goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the member’s behavioral health condition.
- The member and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
- The member is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.
- Required consent for treatment is withdrawn.
- The member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is this level of care required to prevent worsening of the member’s condition.

**Exclusions/Limitations**

- Required consent is not obtained.
- The member is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports.
- The needs identified in the treatment plan that would be addressed by IHT services are
being fully met by other services.

- The environment in which the service takes place presents a serious safety risk to the In-Home Therapy Service provider, alternative community settings are not likely to ameliorate the risk, and no other safe venue is available or appropriate for this service.
- The member is in an independent living situation and is not in the family’s home or returning to a family setting.
- The member has medical conditions or impairments that would prevent beneficial utilization of services.

### MOBILE CRISIS INTERVENTION

**Mobile Crisis Intervention** a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis to identify, assess, treat and stabilize a situation and reduce the immediate risk of danger to the child or others; provided, however, that the intervention shall be consistent with the child’s risk management or safety plan, if any.

The service includes: A crisis assessment; development of a risk management/safety plan, if the member/family does not already have one; up to seven days of crisis intervention and stabilization services including: on-site, face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

**Admission Criteria**

- See Common Criteria

**AND**

- The member must be in a behavioral health crisis that was unable to be resolved to the caller’s satisfaction by phone triage. For member in ICC, efforts by the Care Coordinator and Care Plan Team (CPT) to triage and stabilize the crisis have been insufficient to stabilize the crisis and ESP/MCI has been contacted.
- Immediate intervention is needed to attempt to stabilize the member’s condition safely in situations that do not require an immediate public safety response.
- The member demonstrates impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community.

**AND** at least one of the following:

- The member demonstrates suicidal/assaultive/destructive ideas, threats, plans, or actions that represent a risk to self or others.
- The member is experiencing escalating behavior(s) and, without immediate intervention, he/she is likely to require a higher intensity of services.
- The member is in need of clinical intervention in order to resolve the crisis and/or to remain stable in the community.
- The demands of the situation exceed the parent’s/guardian’s/caregiver’s strengths and capacity to maintain the member in his/her present living environment and external supports are required

**Continuing Stay Criteria**

- NA

**Discharge Criteria**

- See Common Criteria

**AND**
• The crisis assessment and other relevant information indicate that the member needs a more- (or less-) intensive level of care, and the MCI has facilitated transfer to the next treatment setting and ensured that the risk management/safety plan has been communicated to the treatment team at that setting.

• The member’s physical condition necessitates transfer to an inpatient medical facility, and the MCI provider has communicated the member risk management/safety plan to the receiving provider.

• Consent for treatment is withdrawn and there is no court order requiring such treatment.

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**OUTPATIENT CONSULTATION SERVICES**

**Outpatient Consultation Services**

Outpatient Services providers are to utilize case consultation, family consultation, and collateral contacts to involve parents/guardians/caregivers in the planning, assessment, and treatment for members, as clinically indicated, and to educate them on mental health and substance use disorder treatment and relevant recovery issues. Additionally, with member consent and as applicable, Outpatient Services providers are to utilize case consultation and collateral contacts in order to involve the collaterals identified within the Care Coordination section of the General performance specifications in the planning, assessment, and treatment for members. All such activities are to be documented in the member’s health record and releases of information obtained, as required.

**Case Consultation**

A documented meeting of at least 15 minutes duration either in person or by telephone between the treating provider and other behavioral health/medical clinicians or physician, concerning a member who is a client of the behavioral health provider. Goals of case consultation are to identify and plan for additional services, coordinate a treatment plan, review the individual’s progress, and revise the treatment plan, as required.

**Family Consultations**

A documented meeting of at least 15 minutes duration either in person or by telephone between the treating provider and with family members or others who are significant to the member and clinically relevant to a member’s treatment. Goals of family consultation are to educate, identify, and plan for additional services or resources, coordinate a treatment plan, review the individual’s progress, or revise the treatment plan, as required.

**Collateral Contacts**

A documented communication of at least 15 minutes duration either in-person by telephone (including voice mails), or by email. These contacts are between a provider and individuals who are involved in the care or treatment of a Member under the age of 21. This would include, but is not limited to: school and day care personnel, state agency staff, human services agency staff, court appointed personnel, religious or spiritual advisers, and/or other community resources.

**Admission Criteria**

- See Common Criteria.

 AND

- The provider who submits the claim must obtain appropriate documentation, including the date and time of the consultation, names of all parties involved, purpose of consultation, and whether the consultation was in-person or telephonic. Documentation should also include what actions will occur as a result of the consultation.

- For Case Consultations, The meeting is either between two outpatient providers who do not share the same provider number or between the outpatient provider and any behavioral health provider offering services at a different level of care, or between the treating outpatient provider and a representative from a school, state, medical office, or residential provider.

- Multiple providers with different provider numbers may bill for the same consultation/collateral contact if more than one provider is present or on a phone conference.
Continuing Stay Criteria
  • See Common Criteria
  AND
Discharge Criteria
  • See Common Criteria
  AND
Clinical Best Practices
  • See Common Clinical Best Practices
  AND
  • The scope of required service components provided includes, but is not limited to, the following:
    o Treatment coordination
    o Treatment planning with the member’s family or identified supports
    o Implementation of additional or alternative treatment
    o Aftercare planning
    o Termination planning
    o Supporting or reinforcing treatment objectives for the member’s care

THERAPEUTIC MENTORING SERVICES

Therapeutic Mentoring Therapeutic Mentoring offers structured, one-to-one, strength-based support services between a therapeutic mentor and a member for the purpose of addressing daily living, social, and communication needs. Services are designed to support age-appropriate social functioning or to ameliorate deficits in the child’s age-appropriate social functioning; provided, however, that such services may include supporting, coaching and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution and relating appropriately to other children and adolescents and to adults in recreational and social activities; and provided further, that such services shall be provided where the child resides, including in the child’s home, a foster home, a therapeutic foster home or another community setting.

Admission Criteria
  • See Common Criteria
  AND
  • A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths (MA CANS) indicates that the member’s clinical condition warrants this service in order to support age-appropriate social functioning or ameliorate deficits in the member’s age-appropriate social functioning.
  • The member requires education, support, coaching, and guidance image-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to others to address daily living, social, and communication needs and to support the member in a home, foster home, or community setting, OR the member may be at risk for out-of-home placement as a result of the member’s mental health condition OR requires support in transitioning back to the home, foster home, or community from a congregate care setting.
  • Outpatient services alone are not sufficient to meet the member’s needs for coaching, support, and education.
  • Required consent is obtained.
  • The member is currently engaged in outpatient services, In-Home Therapy, or ICC and the provider or ICC CPT determine that Therapeutic Mentoring Services can facilitate the attainment of a goal or objective identified in the treatment plan or ICP that pertains to the development of communication skills, social skills and peer relationships.
Continuing Stay Criteria

- See Common Criteria
  AND
- The member’s clinical condition continues to warrant Therapeutic Mentoring Services in order to continue progress toward treatment plan goals.
- The member’s treatment does not require a more-intensive level of care.
- No less-intensive level of care would be appropriate.
- Care is rendered in a clinically appropriate manner and focused on the member’s behavioral and functional outcomes as described in the treatment plan/ICP.
- Progress in relation to specific behavior, symptoms, or impairments is evident and can be described in objective terms, but goals have not yet been achieved, or adjustments in the treatment plan/ICP to address lack of progress are evident.
- The member is actively participating in the plan of care to the extent possible consistent with his/her condition.
- Where applicable, the parent/guardian/caregiver and/or natural supports are actively involved as required by the treatment plan/ICP.

Discharge Criteria

- See Common Criteria
  AND
- The member no longer meets admission criteria for this level of care or meets criteria for a less or more intensive level of care.
- The treatment plan/ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the member’s behavioral health condition.
- The member and parent/guardian/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
- Required consent for treatment is withdrawn.
- The member is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.
- The member is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.

Clinical Best Practices

- See Common Clinical Best Practices

Exclusions/Limitations

- The member displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more intensive service beyond community-based intervention.
- The member has medical conditions or impairments that would prevent beneficial utilization of services.
- Therapeutic Mentoring services are not needed to achieve an identified treatment goal.
- The member’s primary need is only for observation or for management during sport/physical activity, school, after-school activities, or recreation, or for parental respite.
The service needs identified in the treatment plan/ICP are being fully met by similar services.
The member is placed in a residential treatment setting with no plans for return to the home setting.

REFERENCES

Massachusetts Services
MassHealth Center Based Alert Recommendations. Utilizing Center-Based Applied Behavior Analysis Services for Youth Under the Age of 21 Diagnosed with Autism.

Common Criteria and Clinical Best Practices
American Association of Community Psychiatrists. Level of care utilization system (LOCUS) for psychiatric and addiction services: Adult version 2010.

REVISION HISTORY

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<tr>
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