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. These guidelines are designed to support the behavioral health needs of children/adolescents and their families.

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.

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

The guidance provided for the following services is applicable to children and adolescents under age 19, as defined by M.G.L. c. 175, §47B(c); M.G.L. c. 176A, §8A(c); M.G.L. c. 176B, §4A(c); and M.G.L. c. 176G, §4M(c).2

### 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.

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 discontinuing it. Where there is a reasonable expectation that if treatment were withdrawn the patient’s condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
  - In addition to the above, for outpatient services, some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, coverage depends on whether the criteria discussed above are met; for example, that stability can be maintained without further treatment or with less intensive treatment.

#### Continuing Stay Criteria

- The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active”, service(s) must be as follows:

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2 [https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXI/Chapter176A/Section8A](https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXI/Chapter176A/Section8A)
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:
  o The member’s condition no longer requires care.
  o The member’s condition has changed to the extent that the condition now meets admission criteria for another level of care.
  o Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
  o The member requires medical/surgical treatment that precludes concurrent behavioral health treatment.
  o After an initial assessment the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

COMMON CLINICAL BEST PRACTICES

Introduction

In assessing whether the criteria set forth in these guidelines is satisfied, staff should consider the clinical information collected from the provider following evaluation and treatment planning described in Common Clinical Best Practices. Staff should update the clinical information through continued consultation with the provider at appropriate intervals as the treatment progresses, including information about new or different symptoms or conditions that may emerge in the course of treatment.

Evaluation & Treatment Planning

• The initial evaluation:
  o 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;
  o Focuses on the member’s specific needs;
  o Identifies the member’s goals and expectations;
  o Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

• The provider collects information from the member and other sources, and completes an initial evaluation of the following:
  o The member’s chief complaint;
  o The history of the presenting illness;
  o The factors leading to the request for service;
  o The member’s mental status;
  o The member’s current level of functioning;
  o Urgent needs, including those related to the risk of harm to self, others, and/or property;
  o The member’s use of alcohol, tobacco, or drugs;
  o Co-occurring behavioral health and physical conditions;
  o The member’s history of behavioral health services;
  o The member’s history of trauma;
  o 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.

## IN-HOME BEHAVIORAL SERVICES

**In-Home Behavioral Services:** IHBS services are a combination of medically necessary Behavior Management Therapy and Behavior Management Monitoring and such services are available, when indicated, where the member resides, including in the member’s home, a foster home, a therapeutic foster home or another community setting. In-Home Behavioral Services are delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of Behavior Management Therapy and Behavior Management Monitoring. In-Home Behavioral Services include:

- **Behavior Management Therapy:** Addresses challenging behaviors that interfere with a member’s successful functioning. Services include a functional behavioral assessment and observation of the youth in the home and /or community setting, development of a behavior plan and supervision and coordination of interventions to address specific behavioral objectives or performance. 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.

### Admission Criteria

- See Common Criteria
- AND
- A comprehensive behavioral health assessment conducted by a licensed behavioral health provider 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.
- The comprehensive behavioral health assessment 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.

### Continuing Stay Criteria

- See Common Criteria
- AND
- The member’s clinical condition(s) continues to meet admission criteria 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 and making progress toward treatment goals.
• 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:
  - Identify the goals of the member and family throughout the treatment process;
  - Monitor the progress of the member toward achievement of the goals; and
  - Monitor the progress of the family toward achievement of the goals.
- The provider collaborates with other programs in planning service delivery.

**Services may not be appropriate when:**

- 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)**

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

The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. 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 as described in Common Clinical Best Practices.

**Admission Criteria**

- See Common Criteria
AND

- Safe, efficient, effective assessment and/or treatment of the member’s condition requires the structure of 24-hour/seven days per week treatment setting. Examples include the following:
- Impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered.
- Psychosocial and environmental problems that are likely to threaten the member’s safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

Continuing Stay Criteria

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

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation commensurate with the member’s needs, no later than 24 hours following admission.
- During admission, a psychiatrist is available to consult with the program during and after normal program hours. A psychiatric consultation occurs at least weekly commensurate with the member’s needs.
- 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.

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

Intensive Community-Based Acute Treatment for Children and Adolescents (ICBAT)

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

The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. 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 as described in Common Clinical Best Practices.

Admission Criteria

- See Common Criteria
- The member’s condition and/or the member’s history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be
safely, efficiently, and effectively managed in a less intensive level of care. Examples include:

- A life-threatening suicide attempt;
- Self-mutilation, injury, or violence towards others or property;
- Threat of serious harm to self or others;
- Command hallucinations directing harm to self or others.

OR

- The member’s condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:
  - A physical cause for the member’s signs and symptoms cannot be ruled out in a less intensive setting.
  - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.

OR

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

OR

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

**Continuing Stay Criteria**

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

**Discharge Criteria**

- See Common Criteria

**Clinical Best Practices**

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

**FAMILY STABILIZATION TEAM**

The Family Stabilization Team (FST) program provides intensive, therapeutic services in the home setting to assist the family in stabilizing children and adolescents during a period of emotional,
behavioral, and/or psychiatric disturbance, and secondarily, after out-of-home treatment, such as inpatient hospitalization or community-based acute treatment. This type of program is designed to treat all members of a family, not just the specific child/adolescent identified as being at risk for continued inpatient care, residential treatment, and/or out-of-home placement. Services are designed to prevent repeated hospitalizations or to enable children/adolescents to move to the least restrictive setting as soon as it is clinically indicated, or to foster a successful family reunification. Treatment decisions must include consideration of the resiliency, strengths, and deficits of the child; the ability of the parents to provide the necessary advocacy for meeting the child’s needs; and the ability of the parents to support individuation in the child. Goals of developing positive thoughts, necessary life skills, and strong self-esteem should be included.

Supportive services are delivered during an acute psychiatric episode or following out-of-home treatment (e.g., inpatient care). Programs at this level of care typically use a team approach with both licensed and/or certified professionals and paraprofessionals, delivering a flexible variety of services under a comprehensive and coordinated treatment plan. Services may include counseling, crisis intervention, case management, skill building, mentoring, and other non-traditional services. Family stabilization programs can be used as an independent level of care or as an adjunct to another level of care.

Admission Criteria

- See Common Criteria
  AND
- The member demonstrates symptoms consistent with a DSM diagnosis;
- The member has been admitted to inpatient or residential treatment or is at risk of out of home placement;
- Outpatient services are not sufficient to meet the family’s needs for support and education;
- The family is not receiving duplicative services;
- The member and family give consent and are motivated to participate; and
- The member’s clinical condition warrants this level of care to maintain the member safely in the home and community.

Continued Service Criteria

- See Common Criteria
  AND
- The member’s clinical condition continues to warrant family stabilization services in order to maintain the member in the community and continue progress toward treatment goals.
- The member does not require a more intensive level of care, and a less intensive level of care would not be appropriate.
- Treatment planning is individualized and appropriate to the child/adolescent’s age and changing condition, with realistic, specific, 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 implemented and updated with consideration of all applicable and appropriate treatment modalities.
- The child/adolescent is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition.
- Unless contraindicated, the 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.
- There is documented active discharge planning from the beginning of treatment.
- There is documented active coordination of care with other behavioral health providers and other services and agencies as appropriate.

Discharge Criteria

- See Common Criteria
  AND
- The child/adolescent, parent, and/or legal guardian are not engaged in treatment or in following 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 child/adolescent, parent, and/or guardian have the capacity to make an informed decision, and the child/adolescent does not meet the criteria for a more intensive level of care.

- Consent for treatment is withdrawn. In addition, it is determined that the child/adolescent, parent, and/or guardian have the capacity to make an informed decision, and the child/adolescent does not meet the criteria for a more intensive level of care.
- The child/adolescent 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.
- Support systems that allow the child/adolescent to be maintained in a less restrictive treatment environment have been secured.

### IN-HOME THERAPY

**In-Home Therapy**

In-home services include medically necessary assessment, diagnosis and active behavioral health treatment that are provided in the member’s home. The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. 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 as described in Common Clinical Best Practices.

**Admission Criteria**

- See Common Criteria

In-home outpatient assessment and/or treatment may be covered when the member is homebound. A member is homebound when:

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

In-home outpatient assessment may be covered when:

- An assessment of the changes in the member’s signs and symptoms, and/or psychosocial and environmental factors is required to determine if behavioral health services are needed.
- OR
- An assessment of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.

In-home therapy may be covered when:

- The member’s signs and symptoms are primarily or exclusively experienced at home.
- OR
- The member’s condition undermines participation in treatment at an ambulatory setting.

**Continuing Stay Criteria**

- See Common Criteria

**Discharge Criteria**

- See Common Criteria

**Clinical Best Practices**

- See Common Clinical Best Practices
- The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the
member’s functional status improves, the frequency of visits decreases to meet the member’s current needs and treatment goals. Factors that may impact frequency and duration include the following:
  o The goals of treatment;
  o The member’s preferences;
  o Evidence from clinical best practices which supports frequency and duration;
  o The need to monitor and manage imminent risk of harm to self, others, and/or property.

The provider informs the member of the process to be followed in the event of an after-hours emergency, such as the availability of on-call services. The process is not solely reliant on the Emergency Room. Additional best practices for in-home assessment and treatment are:
• The following conditions may support in-home assessment and/or treatment:
  o Agoraphobia or Panic Disorder;
  o Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairments of thoughts/cognition grossly affect the member’s judgment and decision making, and therefore the member’s safety;
  o Depression with severe vegetative symptoms;
  o Behavioral health problems associated with medical problems that render the member homebound.

**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, and to make referrals and linkages to all medically necessary behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child’s risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.

**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. 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.

**REFERENCES**

**Massachusetts Services**


**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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