



United Behavioral Health

## Supplemental Clinical Criteria: Massachusetts Commercial

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### Table of Contents

[Introduction and Instructions for Use](#)

[Evidence-Based Practice Criteria](#)

[In-Home Behavioral Services](#)

[Behavior Management Therapy](#)

[Behavior Management Monitoring](#)

[Community-Based Acute Treatment for Children and Adolescents \(CBAT\)](#)

[Intensive Community-Based Acute Treatment for Children and Adolescents \(ICBAT\)](#)

[Family Stabilization Team](#)

[In-Home Therapy](#)

[Mobile Crisis Intervention](#)

[References](#)

[Revision History](#)

### INTRODUCTION AND INSTRUCTIONS FOR USE

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

Other *Clinical Criteria*<sup>2</sup> may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®<sup>3</sup>. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member's specific benefits must be referenced.

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

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

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

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

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

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

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

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

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

\*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).<sup>4</sup>

#### EVIDENCE-BASED PRACTICE CRITERIA

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

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

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<sup>4</sup> <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176A/Section8A>

## 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

- 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

- 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

- 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.

### Service Delivery

- 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**

- 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**

- 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 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.

**Service Delivery**

- 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

- 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 the following:
  - 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

- 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.

### **Service Delivery**

- 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**

- 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**

- 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**

- 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**

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.

### Service Delivery

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

The provider informs the member of the process to be followed in the event of an after-hours emergency, such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

Additional best practices for in-home assessment and treatment are:

- The following conditions may support in-home assessment and/or treatment:
  - Agoraphobia or Panic Disorder;
  - Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairments of thoughts/cognition grossly affect the member's judgment and decision making, and therefore the member's safety;
  - Depression with severe vegetative symptoms;
  - 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

- 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.



## Discharge Criteria

- 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

Commonwealth of Massachusetts, Bulletin 2018-07, Access to Services to Treat Child-Adolescent Mental Health Disorders for Commercial Health Insurers, December 14, 2018.

MassHealth Commonwealth of Massachusetts, Executive Office of Health and Human Services, Medical Necessity Criteria. Retrieved from: [www.mass.gov/masshealth](http://www.mass.gov/masshealth)

MassHealth Behavioral Health Services for Children and Member Aged 20 and Younger, A Guide for Staff who Work with Children, Members, and Families. Retrieved from: [www.mass.gov](http://www.mass.gov)

## REVISION HISTORY

Date	Action/Description
07/2019	<ul style="list-style-type: none"><li>• Version 1</li></ul>
01/2020	<ul style="list-style-type: none"><li>• Version 2</li></ul>