



United Behavioral Health

Mississippi Medicaid Level of Care Guidelines

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INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®¹. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

COMMON CRITERIA

Admission Criteria

- The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
 - Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.
 - The member's overall condition includes consideration of the acute and chronic symptoms and diagnoses in the member's history and presentation including co-occurring behavioral health or medical conditions, informed by the information collected by the provider following evaluation and treatment planning described in the Common Best Practices. For children and adolescent members, evaluation of the appropriate treatment and level of care for a member's condition must account for the unique needs of children and adolescents, including age, developmental stage, and the pace at which they respond to treatment, as well as family, caregiver, school and other support systems.

AND

- The member's condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of the member's condition require the intensity and scope of services provided in the proposed level of care.

AND

- Co-occurring behavioral health and medical conditions can be safely and effectively managed in the proposed level of care.

AND

- Services are medically necessary² defined as:
 - Consistent with generally accepted standards of clinical practice;
 - Consistent with services backed by credible research soundly demonstrating that the service(s) will have a measurable and beneficial health outcome, and are therefore not considered experimental;
 - Consistent with Optum's best practice guidelines;
 - Clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks .

AND

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

² There may be variations of the definition of Medical Necessity according to unique contractual or regulatory requirements.

- 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:
 - 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 mental health/substance use disorder condition(s).

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. For children and adolescent members, evaluation of the appropriate treatment and level of care for a member's condition must account for the unique needs of children and adolescents, including age, developmental stage, and the pace at which they respond to treatment, as well as family, caregiver, school and other support systems.

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 that precludes treatment in a mental health or substance use treatment setting
 - After an initial period of stabilization or motivational support, 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;
 - 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.
 - 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 member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation including co-occurring behavioral health or medical conditions, informed by the information collected by the provider following evaluation and treatment planning described in the Common Best Practices;
 - Considers family and other support circumstances.
- The provider collects information from 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 member's condition includes consideration of the acute and chronic symptoms in the member's history and presentation including co-occurring behavioral health or medical conditions, informed by the information collected by the provider following evaluation and treatment planning described in the Common Best Practices.
- 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.

ASSERTIVE COMMUNITY TREATMENT (ACT)

ASSERTIVE COMMUNITY TREATMENT (ACT) is a multi-disciplinary, self-contained clinical team approach providing comprehensive mental health and rehabilitative services. Team members provide long-term intensive care in natural community settings. The team provides all mental health services rather than referring individuals to different mental health providers, programs, and other agencies. Major activities may include: member-specific treatment planning – team meets daily to plan services, assesses individuals community status and share information to coordinate services; individual supports – for activities of daily living, financial management, skills training, medication support; coordination with collaterals – sharing information with healthcare and other providers; individual clinical interventions – therapy, diagnosis and assessment.

Admission Criteria

- The member's physician recommends ACT, and attests that inpatient care would be necessary without this service.

Continued Service Criteria

- The member is not receiving community based mental health services from any provider other than the ACT provider.

AND

- The member is not receiving psychosocial rehabilitation, senior psychosocial rehabilitation, or day support simultaneously with ACT.

Service Delivery

- The Individual Service Plan is developed within the first 14 calendar days.
- The Individual Service Plan is updated at least every 30 calendar days.
- At the time of discharge, the provider gives the parent/guardian:
 - A written copy of the final discharge plan; and
 - A written prescription for a 30-day supply of all medications for the member if the current supply does not exceed 30 days.

COMMUNITY SUPPORT SERVICES (CSS)

COMMUNITY SUPPORT SERVICES (CSS) provides an array of support services delivered by community based mobile professionals. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

CSS not only assists the individual in gaining access to needed services necessary for community integration and sustainability within the community, but may also provide direct services such as supportive counseling/reality orientation, skills training, enlisting social supports, financial management counseling, and monitoring physical and mental health status.

Discharge Criteria

- The enrollee reaches twenty-two (22) years of age or "ages out".
- The enrollee or family utilizes their freedom of choice to end services.
- The enrollee moves out of state.
- The enrollee no longer meets the criteria or needs the intensity of services.
- The enrollee is admitted to an acute care facility or Psychiatric Residential Treatment Facility (PRTF).

Service Delivery

- CSS includes the following as indicated:
 - Identification of strengths which will aid the enrollee in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.
 - Individual therapeutic interventions with an enrollee that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.
 - Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and program toward goals.
 - Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
 - Direct interventions in deescalating situations to prevent crisis.
 - Assisting the enrollee and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.
 - Relapse prevention and disease management strategies.
 - Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.
 - Facilitation of the Individual Service Plan which includes the active involvement of the enrollee and the people identified as important in the enrollee's life.
- The Individual Service Plan is developed within the first 14 calendar days.
- The Individual Service Plan is updated at least every 30 calendar days.
- At the time of discharge, the provider gives the parent/guardian a written copy of the final discharge plan.

DAY TREATMENT

DAY TREATMENT is a behavioral intervention program provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with Serious Emotional Disturbance (SED) the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants in a particular program and may include social skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution. The most important element of Day Treatment is the consistency and qualifications of the staff providing the service. Day Treatment is the most intensive outpatient program available to children and adolescents. Members may participate in the program a maximum of 5 hours per day, five days per week with a minimum of 4 hours per week.

Day Treatment provides an alternative to residential treatment or acute psychiatric hospitalization and/or serves as a transition from these services.

Admission Criteria

- The member has a Serious Emotional Disturbanceⁱ.

Discharge Criteria

- The member reaches 22 years of age.

Service Delivery

- Day Treatment includes involvement of the family or individuals acting in place of the parents as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

INTENSIVE OUTPATIENT TREATMENT

INTENSIVE OUTPATIENT TREATMENT is an all-inclusive, psychiatric clinical suite of multifaceted services acting as a wrap-around to families with children/youth with Serious Emotional Disturbances (SED) for family stabilization in the home and community. It is used to diffuse a current crisis, stabilize the living arrangement and offer the family and children/youth alternatives to being crisis.

Admission Criteria

- The member has a Serious Emotional Disturbanceⁱⁱ.
AND

- The member has a full scale IQ of 60 or above or, if the score is less than 60, there is evidence that the IQ score is suppressed due to the member's behavioral health condition.

AND

- Intensive Outpatient Program is recommended by the member's provider, or is otherwise indicated by the results of a biopsychosocial assessment.

AND

- The member needs specialized services and supports from multiple agencies including case management, and an array of clinical interventions and family supports.

Discharge Criteria

- The member reaches 22 years of age.

Service Delivery

- Intensive Outpatient Program includes involvement of the family or individuals acting in place of the parents as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

MISSISSIPPI YOUTH PROGRAMS AROUND THE CLOCK (MYPAC) SERVICES

Mississippi Youth Programs Around the Clock (MYPAC) are defined as services that are all-inclusive home and community based services that assist members and their families in gaining access to needed mental health services as well as medical, social, educational and other services regardless of the funding source for those other services and includes service coordination that involves finding and organizing multiple treatment and support services. Services are provided to members up to the age of 21 with serious emotional disturbance (SED) that:

- Exceed the resources of a single agency or service provider;
- Experience multiple acute hospital stays;
- Have been recommended for residential care;
- Have had interruptions in delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown;
- Are at immediate risk of requiring treatment in a Psychiatric Residential Treatment Facility (PRTF); or
- Are receiving services in a PRTF and are ready to transition back to the community.

Admission Criteria

- The member:
 - Must be up to the age of 21;
 - Must be diagnosed by a psychiatrist or licensed psychologist in the past 60 days with a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria for SED specified within the Diagnostic and Statistical Manual (DSM);
 - The member can participate and process information as evidenced by and appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness; and
 - Is currently a member of a PRTF or acute care facility who continues to meet the Level of Care (LOC) for residential treatment but can be transitioned into the community with MYPAC services or meets the same LOC for admission to a PRTF but can be diverted to MYPAC as an alternative to residential treatment.
- A member must be admitted prior to their 21st birthday; however, if a member is already receiving MYPAC services prior to age 21, they may remain in MYPAC until treatment is completed or the member's 22 birthday, whichever occurs first.

Continued Service Criteria

- The following documents must be submitted by the provider:
 - A copy of the most current Individualized Service Plan indicating the necessity of continuing the current level of care. Plan should be dated no more than 30 days from the date of the request.
 - A copy of the Child and Family Team Meeting Notes for the past 2 meetings, one of which must have been within the last 30 days.

Discharge Criteria

- Discharge from MYPAC services occurs when:
 - The member reaches 22 years of age;
 - The family utilizes their freedom of choice to end services;
 - The member moves out of state;
 - The member no longer meets the criteria or needs the intensity of services provided; or
 - The member is admitted to an acute care facility or PRTF.
- The wraparound facilitator must access and link appropriate services to the member and family prior to discharge.
- At the time of discharge from MYPAC, the provider must give the parent/guardian:
 - A written copy of the final discharge plan; and
 - A written prescription for 30 day supply of all medications used for the management of the member's SED if the current supply does not exceed 30 days.
- The provider must obtain signed consent from the member and family to provide copies of the final discharge plan to the providers of follow-up mental health, education and other agreed-upon services to be provided after discharge.

Service Delivery

- At the time of the member's discharge from MYPAC services, the discharge/transition plan should be amended to include any of the following, if there is a change:
 - MYPAC services begin and end date;
 - Reason for discharge;
 - The name of the person or agency that cares for and has custody of the member;
 - The physical location/address where the member resides;
 - A list of the member's diagnoses;
 - Detailed information about the member's prescribed medication(s) to treat their SED including:
 - Medication name;
 - Medication strength;
 - Medication dosage instructions in layman's language;
 - Any special instructions for the medication, including but not limited to, lab work requirements.
 - Information connecting the member and family with community resources and services, including but not limited to:
 - Address of where follow-up mental health services will be obtained with contact name and phone number;

- Name and address of the school the member will attend with name and contact information of identified educational staff;
- Other recommended resources, including recreational, rehabilitative, or other special programs including the corresponding contact information;
- Date, time and location of any scheduled appointments.
- Detailed and specific recommendations about the member's participation in the MYPAC program including successful techniques in areas of behavior management, mental health treatment and education; and
- The offer of a full array of community-based mental health services for members.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) services are delivered 24 hours/7 days a week to members under age twenty-one (21) that do not require emergency or acute psychiatric care but do require supervision and treatment on a twenty-four (24) hour basis. The goal of PRTF treatment is to help the individual reach a level of functioning where the least restrictive treatment will be possible.

Admission Criteria

- The member does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis.
AND
- A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges must approve each admission.
AND
- The member has a psychiatric disorder that is documented by the assignment of an appropriate diagnosis, as per the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
AND
- The member can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.
AND
- The member's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.
AND
- The referring psychiatrist or psychologist advises that residential treatment is needed.
AND
- At least one (1) of the following:
 - The member has failed to respond to less restrictive treatment in the last three (3) months.
 - Adequate less restrictive options are not available in the member's community.
 - The member is currently in an acute care facility whose professional staff advise that residential treatment is needed.
 - The admission has been certified as medically and psychologically necessary.

Continued Service Criteria

- Active treatment is being provided to include multidisciplinary diagnostic assessment, interdisciplinary treatment planning, therapeutic intervention, treatment evaluation/revision and discharge and aftercare planning.
AND
- Documentation of treatment successes including which goals have been achieved/not achieved.
AND
- Updates are made to the treatment plan including the re-assessment of the need for continued residential care or less restrictive care.
AND
- Revisions are made to the discharge plan and discharge date as progress is made.

Discharge Criteria

- The member has reached age twenty-two (22).

- OR
- PRTF goals have been met.
- OR
- PRTF goals have not been met, the member is transferred to a more restrictive or less restrictive level of care.
- OR
- PRTF goals have not been met, the member or member's guardian chooses to discontinue services.

Service Delivery

Evaluation and Treatment Planning

- The diagnostic evaluation must document the need for the PRTF level of care.
- Diagnostic evaluations must be completed within the first fourteen (14) days of admission.
- The assessment process must include, but is not limited to, the following:
 - A psychiatric evaluation.
 - A psychological evaluation signed by a licensed psychologist, which must have been completed in the sixty (60) days prior to admission. If no psychological evaluation has been conducted within the last twelve (12) months, one must be completed within fourteen (14) days following PRTF admission.
 - A medical history and examination.
 - A psychosocial assessment, which includes a psychological profile, a developmental profile, a behavioral assessment, and an assessment of the potential resources of the member's family.
 - An educational evaluation.
 - A nursing assessment.
 - A nutritional assessment, if indicated.
- Treatment planning is a collaborative venture in which the members of varying disciplines jointly develop a comprehensive, individualized plan for the treatment of each member.
 - The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible.
 - An initial treatment plan must be in effect within seventy-two (72) hours after the member's admission to the facility.
 - The interdisciplinary treatment team must meet to discuss, approve and implement a more comprehensive treatment plan within fourteen (14) days after the member's admission, once at the conclusion of the first (1st) month of stay, and once a month thereafter.
 - The treatment plan document must contain evidence of the member's and his/her parent/guardian's active participation in the treatment planning/review/revision process.
- At a minimum, the team must include, either:
 - A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry; or
 - A Psychiatric Mental Health Nurse Practitioner (PMHNP) and a physician licensed to practice medicine or osteopathy; or
 - A licensed psychologist and a physician licensed to practice medicine or osteopathy.
- The team must also include one (1) of the following:
 - A licensed certified social worker who has a minimum of one (1) years' experience in treating children with serious emotional disturbances (SED); or
 - A registered nurse who has a minimum of one (1) years' experience in treating individuals with SED.
- The treatment plan outlines all aspects of treatment including:
 - Diagnosis;
 - An assessment of the member's immediate therapeutic needs;
 - An assessment of the member's long-range therapeutic needs;
 - An assessment of the member's personal strengths and liabilities;
 - Identification of the clinical problems that are to be the focus of treatment;
 - Measurable and realistic treatment goals for each identified problem;
 - Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement;
 - Specific treatment modalities and/or strategies that will be employed to reach each objective.

Discharge Planning

- An individualized discharge plan includes:

- Discharge criteria, indicating specific goals to be met;
- An estimated discharge target date; and
- No later than seven (7) days prior to discharge, the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the member;
- When applicable, a minimum of a seven (7) day supply of each of the member's medication(s), and a prescription for a thirty day supply of each of the member's medication(s).

MENTAL HEALTH: 23 HOUR OBSERVATION

23 Hour Observation: *A program that provides a medically-safe environment for up to 23 hours during which the factors that precipitated the need for service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or it is determined that the member's condition requires treatment in a more intensive level of care.*

Admission Criteria

- See Common Criteria
AND
- The factors leading to admission and/or the member's history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The focus of evaluation and treatment planning is to determine whether the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.

MENTAL HEALTH: CRISIS STABILIZATION & ASSESSMENT

Crisis Stabilization & Assessment: *A program in which the factors that precipitated the need for service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member's condition can be safely, efficiently and effectively treated in a less intensive level of care, or it is determined that the member's condition requires treatment in a more intensive level of care.*

There are different types of Crisis Stabilization & Assessment programs. For example, mobile crisis teams are designed to rapidly triage members in crisis who are unable or unwilling to go to an Emergency Room or a facility-based Crisis Stabilization & Assessment program.

More extended and extensive services are offered in Crisis Stabilization & Assessment programs which employ behavioral health professionals and peers to deliver a range of 24-hour services over the course of several days. These programs may be freestanding or co-located with another facility-based program, and the services they provide may include crisis stabilization with/without medication management, peer support, recovery/resiliency planning, an organized sobriety group, social and recreational activities, facilitated access to the next appropriate level of care, and information about community resources.

Admission Criteria

- See Common Criteria
AND

- The factors leading to admission and/or the member's history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The focus of evaluation and treatment planning is to determine whether the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.
- The evaluation addresses the following:
 - Presenting concerns;
 - Urgent needs, including those related to the risk of harm to self, others, and/or property;
 - The history of crises, including:
 - Response to prior interventions;
 - Issues since last crisis stabilization;
 - Current living situation;
 - Availability of supports;
 - Current treatment;
 - Use of alcohol or drugs;
 - Co-occurring behavioral health or medical conditions.
- The treatment plan addresses the following:
 - The member's urgent needs;
 - Immediate services needed to respond to the current crisis;
 - How the member's family and other natural resources will be involved in resolving the crisis when clinically indicated;
 - How the member will be transitioned to other services.

MENTAL HEALTH: INPATIENT

Inpatient: 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.³

*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 and diagnoses 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.*⁴

³ According to the Medicare Benefit Policy Manual, Chapter 16; Section 110 Custodial Care; Custodial care is excluded from coverage: Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. Services which are primarily social, recreational or diversion activities, or custodial or respite care are not reasonable and necessary for inpatient psychiatric services (CMS Psychiatric Inpatient Local Coverage Determinations, 2019).

⁴Active Treatment in an inpatient or residential treatment setting is a clinical process involving the 24-hour care of members that includes assessment, diagnosis, intervention, evaluation of care, treatment and planning for

Admission Criteria

- See Common Criteria
AND
- 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

- 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;
 - 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.

discharge and aftercare under the direction of a psychiatrist that cannot be managed in a less restrictive setting (CMS Psychiatric Inpatient Local Coverage Determinations, 2019). Active Treatment is indicated by services that are all of the following (CMS Benefit Policy Manual, Chapter 2, 30.2.2.1): Supervised and evaluated by a physician; provided under an individualized treatment or diagnostic plan; and reasonably expected to improve the member's condition or for the purpose of diagnosis.

- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

MENTAL HEALTH: OUTPATIENT

Outpatient: *Assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting, via a secure two-way real time interactive telemental health system, or 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 and diagnoses 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. Individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes.*

The following are not considered telemental health because they don't utilize a secure two-way real time interactive telemental health system:

- *Phone-based services including phone counseling, email, texting, voicemail, or facsimile except when allowed by State regulation;*
- *Remote medical monitoring devices;*
- *Virtual reality devices;*
- *Internet-based services including internet-based phone calls.*

Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting 60 minutes or longer. Extended outpatient sessions may require prior authorization before services are received, except in extenuating circumstances, such as a crisis.

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

Admission Criteria

- See Common Criteria
- Coverage for extended outpatient sessions lasting longer than 60 minutes may be indicated in the following non-routine circumstances:
- The member is experiencing a crisis but is not at imminent risk of harm to self or others, and an extended outpatient session is appropriate for providing rapid and time-limited assessment and stabilization.
 - Consider extending coverage for crisis situations in 30-minute increments when clinically indicated.
 - Prior authorization is not required when there is a crisis.
- An individual psychotherapy session with evaluation and management is being provided, and there is an unexpected complication resulting from pharmacotherapy, or a worsening of the member's condition that would likely require a more intensive level of care if the outpatient session is not extended.
- Periodic involvement of children, adolescent, or geriatric members' family in a psychotherapy sessions when such involvement is essential to the member's progress (e.g., when psychoeducation or parent management skills are provided).
 - This is not synonymous with marital or family therapy.
- An extended session is otherwise needed to address new symptoms of the reemergence of old symptoms with a rapid, time-limited assessment and stabilization response. Without an extended outpatient session, the new-re-emerging symptoms are likely to worsen and require a more intensive level of care.

Extended outpatient sessions may be covered in the following circumstances, as indicated by the member's condition and specific treatment needs:

- The member has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder, Obsessive Compulsive Disorder, or Specific Phobia, and is being treated with Prolonged Exposure Therapy.
- The member is being treated with Eye Movement Desensitization and Reprocessing (EMDR) or Traumatic Incident Reduction (TIR) for Posttraumatic Stress Disorder (PTSD).
- Borderline Personality Disorder is a covered condition, and the member is being treated with Dialectical Behavior Therapy (DBT).

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

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

Home-based 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.
- An assessment of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.

Home-based outpatient treatment may be covered when:

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

Coverage for outpatient telemental health service may be covered when:

- The Outpatient Admission Criteria are met.
AND
- A secure two-way real time interactive telemental health system is available to facilitate interaction between the member and the provider.

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:
 - 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 home-based assessment and treatment are:

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

Additional best practices for telemental health are:

- Asynchronous store and forward technologies (i.e., the transmission of a member's clinical record, lab results, or other clinical information from an originating site to the provider at a distant site) is not part of the standard of care for telemental health.
- The following are not considered telemental health because they don't utilize a secure two-way real time interactive telemental health system:

- Phone-based services including phone counseling, email, texting, voicemail, or facsimile except when allowed by State regulation;
- Remote monitoring devices;
- Virtual reality devices;
- Internet-based services including internet-based phone calls.
- A qualified provider at the distant site is licensed in the state where the member resides.
- Delivery of group or family psychotherapy to members at different locations (i.e., multipoint videoconferencing) may be covered when all members are in the state where the provider is licensed, and all locations provide secure two-way real time interactive telemental health systems.
- Services are delivered in a manner consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security regulations and standards.

MENTAL HEALTH: PARTIAL HOSPITAL PROGRAM

Partial Hospital Program: *A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. While a Partial Hospital Program generally maintains at least 20 hours of service per week, the frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.*

Partial Hospital Programs provide education, treatment, and the opportunity to practice new skills outside the program.

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 and diagnoses 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.

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

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

Admission Criteria

- See Common Criteria
AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include the following:
 - Assessment requires frequent interaction with the member, and observation of the member with others.
 - The treatment plan must be changed frequently, which requires that the provider have face-to-face interactions with the members several times a week.
- OR
- The member requires engagement and support, which requires extended interaction between the member and the program. Examples include the following:
 - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center, such as engagement with wraparound services or natural resources.
 - The member has been unable to access or utilize family or other natural resources on his or her own.
- OR
- The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
 - Maintain their current living situation;
 - Return to work or school.
- OR

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

Additional Criteria for Overnight Housing Coupled with a Partial Hospital Program

- Overnight housing is covered by the benefit plan.
AND
- The treatment setting is separate from the housing.
AND
- Either of the following apply:
 - An unsupportive or high-risk living situation is undermining the member's recovery;
 - Routine attendance at a Partial Hospital Program is hindered by a lack of transportation.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The psychiatrist and treatment team complete 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 business hours.
- A psychiatrist sees the member commensurate with the member's needs, with no less than weekly visits.
- The frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.

MENTAL HEALTH: RESIDENTIAL TREATMENT CENTER

Residential Treatment Center: *A facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.*⁵

*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 and diagnoses 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.*⁶

Admission Criteria

⁵ According to the Medicare Benefit Policy Manual, Chapter 16; Section 110 Custodial Care; Custodial care is excluded from coverage: Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. Services which are primarily social, recreational or diversion activities, or custodial or respite care are not reasonable and necessary for inpatient psychiatric services (CMS Psychiatric Inpatient Local Coverage Determinations, 2019).

⁶ Active Treatment in an inpatient or residential treatment setting is a clinical process involving the 24-hour care of members that includes assessment, diagnosis, intervention, evaluation of care, treatment and planning for discharge and aftercare under the direction of a psychiatrist that cannot be managed in a less restrictive setting (CMS Psychiatric Inpatient Local Coverage Determinations, 2019). Active Treatment is indicated by services that are all of the following (CMS Benefit Policy Manual, Chapter 2, 30.2.2.1): Supervised and evaluated by a physician; provided under an individualized treatment or diagnostic plan; and reasonably expected to improve the member's condition or for the purpose of diagnosis.

- See Common Criteria
AND
- Safe, efficient, effective assessment and/or treatment of the member's condition requires the structure of a 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
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 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 member;
 - 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.

WRAPAROUND SERVICES: CASE MANAGEMENT

Case Management: *A community-based program in which a behavioral health professional or trained peer assists members who are at risk of being underserved in their efforts to identify, access, and utilize medical, behavioral health, or social services, or to otherwise achieve recovery and resiliency goals. 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 and diagnoses 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.*

Targeted Case Management is a form of case management services provided only to specific classes of members, or to members who reside in specified areas.

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

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

Admission Criteria

- See Common Criteria
AND

- The member's condition indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:
 - The member requires assistance with navigating the system of care.
 - The member requires assistance with accessing transportation services, employment services, childcare, or other community resources.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The responsible Case Manager, in conjunction with the treatment team, completes an initial evaluation of the member's case management needs upon admission.
- The responsible Case Manager, in conjunction with the treatment team and, whenever possible, the member, develops a service plan that includes a description of the following:
 - The member's recovery and resiliency goals;
 - Strengths;
 - Problems;
 - Specific and measurable goals for each problem;
 - Interventions that will support the member in meeting the goals.
- The service plan may be informed by the findings of the initial clinical evaluation.
- With the member's permission, the Case Manager advocates for the member by sharing feedback about the member's experience with the treatment provider, as well as agencies or other programs with which the member is involved.

WRAPAROUND SERVICES: FAMILY PEER SERVICES AND SUPPORTS

Family Peer Services and Supports: *Family Peer Services and Supports provides families and other caregivers with support, information, and the opportunity to develop skills in support of a member's recovery and resiliency. While providing these services, the family peer utilizes his/her training, lived experience and experiential knowledge to reduce the likelihood that the family and member will become isolated, disempowered, or disengaged. 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 and diagnoses 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.*

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

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

Admission Criteria

- See Common Criteria
- AND
- The member has a Serious Emotional Disturbance (SED) or a Substance-Related Disorder.
- AND
- The member's condition indicates that the member's family and member require assistance with accessing treatment and/or community resources. Examples include:
 - The member's family requires information about the member's behavioral health condition, evidence-based treatment, approaches to self-care, or community resources.
 - The member's family could benefit from learning skills related to problem-solving, communication, managing crises or stress, supporting and engaging the child's activation and self-care, or promoting recovery and resiliency.

- The member's family requires assistance navigating the system of care.

AND

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

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The family peer completes an evaluation of the family's needs upon referral.
 - For members who are transitioning from Inpatient or Residential Treatment, the family peer contacts the member's family prior to discharge or within 24 hours of referral.
- As part of the evaluation, the family peer provides the member's family with information about Family Peer Services and Supports, and verifies that the member's family wants these services.
 - In the event that the member's family declines services, the family peer provides information about obtaining services should the family's needs change.
- The family peer, in conjunction with the member's family, develops a service plan that addresses the following:
 - The member's resiliency goals;
 - The member and family's strengths;
 - The member and family's educational needs;
 - The member and family's self-care needs and resources;
 - Problems;
 - Specific and measurable goals for each problem;
 - Interventions that will support the member's family and member in meeting the goals.
- The service plan may be informed by the findings of the member's clinical evaluation.

WRAPAROUND SERVICES: PEER SERVICES AND SUPPORTS

Peer Services and Supports: *Peer Services and Supports provides members with support, information, and the opportunity to develop skills in support of the member's recovery. While providing these services, the Peer utilizes his/her training, lived experience, and experiential knowledge to reduce the likelihood that the member will become isolated, disempowered, or disengaged. 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 and diagnoses 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.*

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

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

Admission Criteria

- See Common Criteria
- AND
- The member has a Serious Mental Illness (SMI) or a Substance-Related Disorder
- AND
- The member's condition indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:

- The member requires information about their behavioral health condition, evidence-based treatment, approaches to self-care, or community resources;
- The member could benefit from learning skills related to problem-solving, communication, managing crises or stress, activating and engaging in self-care, or promoting recovery;
- The member requires assistance navigating the system of care.

AND

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

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The Peer completes an evaluation of the family's needs upon referral.
 - For members who are transitioning from inpatient or residential treatment, the Peer contacts the member's family prior to discharge or within 24 hours of referral.
- As part of the evaluation, the Peer provides the member with information about Peer Services and Supports, and verifies that the member wants these services.
 - In the event that the member declines services, the Peer provides information about obtaining services should the family's needs change.
- The Peer, in conjunction with the member's family, develops a service plan that addresses the following:
 - The member's recovery and resiliency goals;
 - The member's strengths;
 - The member's educational needs;
 - The member's self-care and activation strategies;
 - Problems;
 - Specific and measurable goals for each problem;
 - Interventions that will support the member in meeting the goals.
- The service plan may be informed by the findings of the member's clinical evaluation.

WRAPAROUND SERVICES: PSYCHOSOCIAL REHABILITATION

Psychosocial Rehabilitation: A program that promotes recovery, full community integration, and improved quality of life for members who have been diagnosed with a behavioral health condition that seriously impairs their ability to lead meaningful lives. Interventions aim to help members develop skills and access resources needed to increase their capacity to succeed in their living, working, learning, and social environments. Interventions are collaborative, person-directed, individualized, and based on the member's capacity for recovery. 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 and diagnoses 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.

Psychosocial Rehabilitation is provided in conjunction with traditional pharmacologic and psychosocial treatments.

Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to support the member's ability to manage functional difficulties and realize recovery and resiliency goals.

Admission Criteria

- See Common Criteria

AND

- The member's condition indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:

- The member has difficult gaining and utilizing necessary functional skills, such as those related to:
 - Education or work;
 - Finances;
 - Housing;
 - Health/medical;
 - Social needs;
 - Basic living skills;
 - Legal needs.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria
- The discharge plan:
 - Identifies the member's progress meeting their rehabilitation goal(s);
 - Identifies the plan for services and supports needed to further assist the member with community integration, recovery, and realizing a higher quality of life;
- Includes information on the continuity of the member's medications.

Clinical Best Practices

- See Common Clinical Best Practices
- Services are organized around:
 - The member's stated goals;
 - The member's preferences;
 - The identified needs of the member;
 - Improving the member's ability to understand their needs;
 - Assisting the member with achieving goal, such as:
 - Community living skills, including food planning and preparation, money management, maintenance of living environment, etc.;
 - Interpersonal relations;
 - Recreation or use of leisure time activities;
 - Vocational development or employment;
 - Educational development;
 - Self-advocacy;
 - Access to non-disability related social resources.
- The responsible provider, in conjunction with the rehabilitation team, completes the initial evaluation of the following within 24 hours of admission:
 - Factors leading the member to access services;
 - Assessment of harm to self, others, and/or property;
 - The member's readiness for rehabilitation;
 - The member's overall rehabilitation goal(s);
 - The member's functional skills and knowledge in relation to the overall rehabilitation goal(s);
 - The member's resources in relation to the overall rehabilitation goal(s).
- The responsible provider, in conjunction with the rehabilitation team and whenever possible, the member, develops a multidisciplinary rehabilitation plan that focuses on the following:
 - The member's rehabilitation goal(s);
 - The member's present level of skills and knowledge relative to the rehabilitation goal(s);
 - The skills and knowledge needed to achieve the member's rehabilitation goal(s);
 - The member's present resources and the resources needed to achieve the member's rehabilitation goal.
- The rehabilitation plan includes specific and measurable objectives aimed at assisting the member with achieving the rehabilitation goal(s), and interventions for each skill, knowledge, or resource objective.
- The rehabilitation plan may be informed by the findings of the initial clinical evaluation.
- When the initial assessment identifies a potential risk of harm to self, others, and/or property, a personal safety plan is completed that includes:

- Triggers;
- Current coping skills;
- Warning signs;
- Preferred interventions;
- Advance directives, when available.
- The program provides an effective system for reaching out to members who are not attending, becoming isolated, or who are hospitalized.

WRAPAROUND SERVICES: RESPITE CARE

Respite Care: *Respite Care is a temporary care that is intermittently provided to members with a Serious Mental Illness (SMI) or a Serious Emotional Disturbance (SED) when the family/caregiver requires a temporary break from caregiving, when members are at risk for abuse or neglect, or when members need additional support following a crisis. Respite Care can include assistance with Activities of Daily Living (ADLs), reinforcing life skills, or otherwise supporting the member's recovery and resiliency goals. 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 and diagnoses 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. Respite Care can include assistance with Activities of Daily Living, reinforcing life skills, or otherwise supporting the member's recovery and resiliency goals.*

Respite Care is provided in the member's home, or in a community-based setting, such as a day care center. The duration of Respite Care also varies, and may include an overnight stay.

Admission Criteria

- See Common Criteria
AND
- The member's condition indicates that the member's family or caregiver requires a temporary break from caregiving. Examples include:
 - The stress of caregiving has put the member at imminent risk of abuse or neglect.
 - Other responsibilities temporarily prevent the member's family or caregiver from assisting the member with Activities of Daily Living (ADLs).

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The responsible provider evaluates the member and caregiver's need upon admission.
- The responsible provider, in conjunction with the member and/or member's family or caregiver, develops a service plan that includes the following:
 - The goal(s) of Respite Care;
 - Specific, measurable objectives aimed at achieving the goal(s) of Respite Care.
- The service plan incorporates instructions for medical care, special needs and emergencies.
- The service plan also addresses the need for other services and resources that become apparent during the provision of Respite Care. As needed, the provider assists the member with accessing other services and resources.
- The service plan may be informed by the findings of the initial clinical evaluation.
- The provider ensures that necessary medication, medical equipment, and assistive technology accompany the member when Respite Care is provided at a site other than the member's residence.

WRAPAROUND SERVICES: SOBER LIVING ARRANGEMENTS

Sober Living Arrangements: *Sober Living Arrangements (a.k.a. Drug-Free Housing, Alcohol/Drug Halfway House) are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment, and support for recovery from alcohol or drug use. 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 and diagnoses 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.*

Sober Living Arrangements vary in intensity and duration in order to support the member's ability to utilize behavioral health services, manage functional difficulties, and otherwise realize recovery goals.

Admission Criteria

- See Common Criteria
AND
- There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
AND
- The member's condition indicates that the member's recovery from alcohol or drug use requires the structure and support available in a Sober Living Arrangement. Examples include:
 - The member's environment doesn't support recovery to the extent that the member is at risk of relapse.
 - The member is isolated and needs the structure and support available in a Sober Living Arrangement to practice relapse prevention.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The responsible staff member evaluates the member's needs upon admission.
- The responsible staff member and the member develop a service plan that includes the following:
 - The goal of the Sober Living Arrangement; and
 - Specific, measurable objectives aimed at achieving the goal(s) of the Sober Living Arrangement.
- The responsible staff member provides the members with information about:
 - Accessing community resources;
 - Accessing emergency care;
 - Dealing with onsite safety issues, including:
 - Environmental risks;
 - Abuse or neglect;
 - Self-protection;
 - Medication management;
 - Guidelines related to guests.
- The responsible staff member ensures that the following are provided:
 - Regular meetings with staff;
 - Opportunities to improve Activities of Daily Living (ADLs);
 - Linkages with behavioral health and medical services.
- The service plan may be informed by the findings of the initial clinical evaluation.

WRAPAROUND SERVICES: SUPERVISED LIVING ARRANGEMENTS

Supervised Living Arrangements: *Supervised Living Arrangements are residences such as transitional living facilities, group homes, and supervised apartments that provide a member with a Serious Mental Illness (SMI) with stable and safe housing, 24-hour supervision, the opportunity to learn how to manage Activities of Daily Living (ADLs), and support for the member's broader recovery*

and resiliency goals. 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 and diagnoses 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.

Supervised Living Arrangements vary in the amount of available staff, the intensity of recovery and resiliency-related services, and the length of residence.

Admission Criteria

- See Common Criteria
AND
- The member has a Serious Mental Illness (SMI)
AND
- The member's condition indicates that the member is unable to maintain tenure in the community without the structure and support available in a Supervised Living Arrangement. Examples include:
 - The member is unable to maintain a safe living environment or sustained housing to the extent that the member is at risk for admission.
 - The member requires a transitional period of supervised living after discharge from inpatient or residential treatment.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The responsible staff member evaluates the member's needs upon admission.
- The responsible staff member and the member develop a service plan that includes the following:
 - The goal(s) of the Supervised Living Arrangement; and
 - Specific, measurable objectives aimed at achieving the goal(s) of the Supervised Living Arrangement.
- The responsible staff member provides the member with information about:
 - Accessing community resources;
 - Accessing emergency care;
 - Dealing with onsite safety issues, including:
 - Environmental risks;
 - Abuse or neglect;
 - Self-protection;
 - Medication management;
 - Guidelines related to guests.
- The responsible staff member ensures that the following are provided:
 - Regular meetings with staff;
 - Opportunities to improve Activities of Daily Living (ADLs);
 - Linkages with behavioral health and medical services.
- The service plan may be informed by the findings of the initial clinical evaluation.

WRAPAROUND SERVICES: THERAPEUTIC FOSTER CARE

Therapeutic Foster Care: *Therapeutic Foster Care provides a structured home environment in which specifically trained foster parents teach social, behavioral, and emotional skills to children and adolescents who are at risk of placement, or who have complex and significant behavioral health problems which cannot be managed at 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 and diagnoses 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.

Placements in a therapeutic foster home are usually limited to two youths per family. Whenever appropriate, Therapeutic Foster Care supports family permanence by also training the parent(s)/guardian(s) to manage the member's needs and behavior, and by providing case management.

Therapeutic Foster Care varies in intensity and duration in order to support the member's ability to manage functional difficulties and enhance the member's resiliency.

Admission Criteria

- See Common Criteria
AND
- The member's condition indicates that the member cannot be suitably cared for in the member's home. Examples include:
 - The member is at risk for placement.
 - The member has complex and significant behavioral health problems that cannot be managed by the member's family or caregiver.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The responsible Therapeutic Foster Care provider evaluates the member's needs as well as the needs of the family or caregiver upon admission.
- The responsible Therapeutic Foster Care provider, in conjunction with the member and/or member's family or caregiver, develops a plan that includes a description of the following:
 - The goal of Therapeutic Foster Care;
 - Objectives aimed at achieving the goal(s) of Therapeutic Foster Care, including interventions aimed at promoting effective parenting skills as appropriate.
- The plan includes instructions for accessing behavioral health services.

REFERENCES

Mississippi References

Mississippi Division of Medicaid Administrative Code, Title 23: Part 207, Chapter 4: Psychiatric Residential Treatment Facilities. Retrieved from: <https://www.medicaid.ms.gov/wp-content/uploads/2015/09/AdminstrativeCode.pdf>

Mississippi Division of Medicaid Administrative Code, Title 23: Part 208, Chapter 7: 1915 (i) HCBS for Individuals with Intellectual Disabilities (ICF/IID). Retrieved from: <https://www.medicaid.ms.gov/wp-content/uploads/2015/09/AdminstrativeCode.pdf>

Mississippi Division of Medicaid Administrative Code, Title 23: Part 206, Chapter 2: Mississippi Youth Programs Around the Clock (MYPAC). Retrieved from: <https://www.medicaid.ms.gov/wp-content/uploads/2015/09/AdminstrativeCode.pdf>

State of Mississippi, Department of Mental Health. (2016). Department of Health Record Guide for Mental Health, Intellectual and Developmental Disabilities, and Substance Abuse Community Providers. Retrieved from: <http://www.dmh.ms.gov/wp-content/uploads/2016/06/Final-2016-DMH-Record-Guide.pdf>

State of Mississippi, Mississippi Division of Medicaid. (2014). Mississippi Medicaid provider reference guide for Part 206. Retrieved from: <https://medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-206.pdf>

Common Criteria and Common Clinical Best Practices

American Association of Community Psychiatrists. Child and adolescent level of care utilization system (CALOCUS) 2010.

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

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed.) 2013; Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. Practice guidelines for the psychiatric evaluation of adults (3rd ed.) 2015; Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors 2003; Arlington, VA: American Psychiatric Publishing.

Centers for Medicare and Medicaid Services. Benefit policy manual, chapter 2 – inpatient psychiatric hospital services 2016. Retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>

Centers for Medicare and Medicaid Services. Benefit policy manual, chapter 6 – hospital services covered under Part B 2015. Retrieved from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>

Commission on Accreditation of Rehabilitation Facilities. Behavioral health standards manual 2017. Tucson, AZ: CARF International.

Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., & Miller, M.M., (eds). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013.

Mental Health

Agency for Healthcare Research and Quality. Psychological and pharmacological treatments for adults with post-traumatic stress disorder (PTSD): A systematic review. May 24, 2017. Retrieved from https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/ptsd-adult-treatment-update_research-protocol.pdf .

American Association of Community Psychiatrists. Child and adolescent level of care utilization system (CALOCUS) 2010.

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

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed.) 2013; Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. Practice guidelines for the psychiatric evaluation of adults (3rd ed.) 2015; Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors 2003; Arlington, VA: American Psychiatric Publishing.

Association for Ambulatory Behavioral Healthcare. Standards and guidelines for partial hospital programs (5th ed.) 2015. Association for Ambulatory Behavioral Healthcare.

Centers for Medicare and Medicaid Services. Benefit policy manual, chapter 6 – hospital services covered under part B 2015. Retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf>

Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, Chapter 2, Inpatient Psychiatric Hospital Services. Retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c02.pdf>.

Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, Chapter 16, General Exclusions from Coverage. Retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf>.

Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD): Home Health – Psychiatric Care (L34561). Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34561&ver=22&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=Home+health+psychiatric+care&KeywordLookup=Title&KeywordSearchType=And&bc=gAAAAA%3d%3d&>

Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD): Outpatient observation bed/room services (L34552). Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34561&ver=32&DocType=Active&bc=AAIAAAAAAAAA%3d%3d&>

Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD): Psychiatric diagnostic evaluation and psychotherapy services (L33252). Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33252&ver=18&DocType=Active&bc=AAIAAAAAAAAA%3d%3d&>

Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD): Psychiatric Inpatient Hospitalization (L34183; L33975; L33624; L34570). Retrieved from: <https://www.cms.gov/medicare-coverage-database/search/search-results.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=psychiatric+inpatient&KeywordLookup=Title&KeywordSearchType=And&bc=gAAAAA%3d%3d&=&>

Centers for Medicare and Medicaid Services. Local Coverage Determination (LCD): Psychiatric Partial Hospitalization Programs (L33972; L34196; L33626). Retrieved from: <https://www.cms.gov/medicare-coverage-database/search/search-results.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=psychiatric+partial&KeywordLookup=Title&KeywordSearchType=And&bc=gAAAAA%3d%3d&=&>

Code of Federal Regulations 2015. 42 CFR 410.78; Telehealth Services. Retrieved from: <https://www.law.cornell.edu/cfr/text/42/410.78>

Commission on Accreditation of Rehabilitation Facilities. Behavioral health standards manual 2017. Tucson, AZ: CARF International.

Grady B, Myers KM, Nelson EL, Belz N, Bennett L, Carnahan L, Decker VB, Holden D, Perry G, Rosenthal L, Rowe N, Spaulding R, Turvey CL, White R, Voyles D, & the American Telemedicine Association Telemental Health Standards and Guidelines Working Group. Evidence-based practice for telemental health. *Telemed J E Health* 2011; 17(2):131-148.

Hilty D, Yellowlees PM, Parrish MB, & Chan S. Telepsychiatry: Effective, evidence-based, and at a tipping point in health care delivery? *Psychiatr Clin North Am* 2015; 38(3):559-592.

Joint Task Force for the Development of Telepsychiatry Guidelines for Psychologists. Guidelines for the Practice of Telepsychology 2013; 68(9):791-800.

MacPherson HA, Cheavens JS, & Fristad MA. Dialectical behavior therapy in adolescents: Theory, treatment adaptations, and empirical outcomes. *Clin Child Fam Psychol Rev* 2013; 16(1):59-80.

Murphy S, Irving CB, Adams CE, & Driver R. Crisis intervention for people with severe mental illnesses. *Cochrane Database Syst Rev* 2015; (12):CD001087.

Myers K, Cain S, & the Work Group on Quality Issues (WGQI). Practice parameter for telepsychiatry with children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry* 2008; 47(12):1468-1483.

Rizvi SL, Steffel LM, & Carson-Wong A. An overview of dialectical behavior therapy for professional psychologists. *Professional Psychology: Research and Practice* 2013; 44(2):73-80.

Substance Abuse and Mental Health Services Administration. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). Traumatic Incident Reduction 2011. Retrieved from: <https://detoxrehab.com/treatment-programs/traumatic-incident-reduction-therapy-tir-substance-abuse>

Turvey C, Coleman M, Dennison O, Drude K, Goldenson M, Hirsch P, Jueneman R, Kramer GM, Luxton DD, Maheu MM, Malik TS, Mishkind MC, Rabinowitz T, Roberts LJ, Sheeran T, Shore JH, Shore P, van

Heeswyk F, Wregglesworth B, Yellowlees P, Zucker ML, Krupinski EA, Bernard J. ATA practice guidelines for video-based online mental health services. *Telemed J E Health* 2013; 19(9):722-730.

Wraparound Services

Allness DJ, & Kniedler WH. *A Manual for ACT Start-Up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illness* 2003. Arlington, VA: NAMI

American Psychiatric Association. *Guideline watch: Practice guideline for the treatment of patients with substance use disorders (2nd ed.)* 2007; Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. *Practice guideline for the treatment of patients with substance use disorders (2nd ed.)* 2006; Arlington, VA: American Psychiatric Publishing.

Anthony WA, & Farsak MD. *Primer on the psychiatric rehabilitation process* 2009. Boston: Boston University Center for Psychiatric Rehabilitation.

Bazelon Center for Mental Health Law. *Permanent supportive housing: The most effective and integrated housing for people with mental disabilities* 2010. Retrieved from:

<http://www.bazelon.org/wp-content/uploads/2017/04/supportive-housing-fact-sheet.pdf>

Bond GR, & Drake RE. The critical ingredients of assertive community treatment. *World Psychiatry* 2015; 14(2):240-242.

Boyd LW. *Therapeutic foster care: Exceptional care for complex, trauma-impacted youth in foster care* 2013. State Policy Advocacy and Reform Center. Retrieved from:

<https://childwelfareparc.files.wordpress.com/2013/07/therapeutic-foster-care-exceptional-care-for-complex-trauma-impacted-youth-in-foster-care.pdf>

Case Management Society of America. *Standards of practice for case management* 2010. Retrieved from: <http://solutions.cmsa.org/acton/media/10442/standards-of-practice-for-case-management>

Center for Substance Abuse Treatment, *What are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Code of Federal Regulations. 42 CFR 440.169 - Case Management Services 2009. Retrieved from: <http://www.ecfr.gov>

Coldwell CM & Bender WS. The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *Am J Psychiatry* 2007; 164(3):393-399.

Commission on Accreditation of Rehabilitation Facilities. *Behavioral health standards manual* 2017. Tucson, AZ: CARF International.

Dietrich M, Irving CB, Park B, & Marshall M. Intensive case management for severe mental illness. *Cochrane Database Syst Rev* 2010; 10:CD0077906.

Dixon LB, Dickerson F, Bellack AS, Bennett M, Dickinson D, Goldberg RW, Lehman A, Tenhula WN, Calmes C, Pasillas RM, Peer J, Kreyenbuhl J, & the Schizophrenia Patient Outcomes Research Team (PORT). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr Bull* 2010; 36(1):48-70.

Dixon LB, Lucksted A, Medoff DR, Burland J, Stewart B, Lehman AF, Fang LJ, Sturm V, Brown C, & Murray-Swank A. Outcomes of a randomized study of a peer-taught family-to-family education program for mental illness. *Psychiatr Serv* 2011; 62(6):591-597.

Edgar M, & Uhl M. *National respite guidelines: Guiding principles for respite models and services* 2011. ARCH National Respite Network and Resource Center; Annandale, VA.

Hahn RA, Bilukha O, Lowy J, Crosby A, Fullilove MT, Liberman A, Moscicki E, Snyder S, Tuma F, Corso P, Schofield A, & the Task Force on Community Preventive Services. The effectiveness of therapeutic foster care for the prevention of violence: A systematic review. *Am J Prev Med* 2005; 28(2 Suppl 1):72-90.

Lyman DR, Kurtz MM, Farkas M, George P, Dougherty RH, Daniels AS, Ghose SS, & Delphin-Rittmon ME. Skill building: Assessing the evidence. *Psychiatr Serv* 2014; 65(6):727-738.

Management of Substance Use Disorders Work Group. VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorders, version 3.0. Washington, DC: Veterans Health Administration and Department of Defense; 2015.

McGuire AB, Kukla M, Green A, Gilbride D, Mueser KT, & Salyers MP. Illness management and recovery: A review of the literature. *Psychiatr Serv* 2014; 65(2):171-179.

Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend, DR, & Miller MM, (eds). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd ed. Carson City, NV: The Change Companies; 2013.

Mueser KT, Bond GR, Drake RE, Resnick SG. Models of community care for severe mental illness: A review of research on case management. *Schizophr Bull* 1998; 24(1):37-74.

National Alliance on Mental Illness. How housing can help heal 2014. Retrieved from: <https://www.impactingourfuture.com/affordable-housing/how-housing-helps-supporting-recovery-for-people-with-mental-illness/#>

National Association of Social Workers (NASW). NASW standards for social work case management 2013. Retrieved from: <https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0>

National Respite Network and Resource Center. Respite for caregivers of children with serious emotional disturbance: Fact Sheet Number 34, June 2012. Retrieved from: http://www.taese.org/cms/images/utahstate_media/documents/FS_34-SeriousEmotionalDisturbance_Respite6_15_12.pdf

Pfeiffer PN, Heisler M, Piette JD, Rogers MA, & Valenstein M. Efficacy of peer support interventions for depression: A meta-analysis. *Gen Hosp Psychiatry* 2011; 33(1):29-36.

Pickett-Schenk SA, Lippincott RC, Bennett C, & Steigman PJ. Improving knowledge about mental illness through family-led education: The journey of hope. *Psychiatr Serv* 2008; 59(1):49-56.

Psychiatric Rehabilitation Association (PRA). About PRA: Defining psychiatric rehabilitation 2016. Retrieved from: <http://www.uspra.org/about-pra>

Resnick SG, & Rosenheck RA. Integrating peer-provided services: A quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatr Serv* 2008; 59(11):1307-1314.

Romanelli LH, LaBarrie T, Hackler D, & Jensen PS. Implementing evidence-based practice in treatment foster care: A resource guide 2008. Foster Family-Based Treatment Association; Hackensack, NJ.

Stull LG, McGrew JH, & Salyers MP. Processes underlying treatment success and failure in assertive community treatment. *J Ment Health* 2012; 21(1):49-56.

Substance Abuse and Mental Health Services Administration. Assertive Community Treatment (ACT) Evidence-Based practices (EBP) KIT. Retrieved from: <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Substance Abuse and Mental Health Services Administration. Illness Management and Recovery: Practitioner Guides and Handouts. HHS Pub. No. SMA-09-4462. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Substance Abuse and Mental Health Services Administration. Permanent Supportive Housing: How to Use the Evidence-Based Practices KITs. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2010.

Substance Abuse and Mental Health Services Administration. Permanent Supportive Housing: The Evidence. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and mental Health Services Administration, U.S. Department of Health and Human Services, 2010.

Task Force on Community Preventive Services. Recommendations to reduce violence through early childhood home visitation, therapeutic foster care, and firearms laws. *Am J Prev Med* 2005; 28(2 Suppl 1):6-10.

REVISION HISTORY

Date	Action/Description
03/22/2004	<ul style="list-style-type: none"> Version 1. Revision histories for pre-2004 iterations not known.
01/31/2016	<ul style="list-style-type: none"> Version 13. Annual review. Updates based on changes in the evidence-base as well as input.
01/10/2017	<ul style="list-style-type: none"> Version 14. Annual review. Updates based on changes in the evidence-base as well as input. ECT and TMS Level of Care Guidelines converted to Behavioral Clinical Policies. New format.
05/09/2017	<ul style="list-style-type: none"> Version 15. Mid-cycle review. Re-inserted guidance about home-based outpatient treatment from the 2016 Level of Care Guidelines.
02/07/2018	<ul style="list-style-type: none"> Version 16. Annual review. No significant changes.
05/09/2018	<ul style="list-style-type: none"> Version 17. Mid-cycle review. New template. Updates based on additional guidance from Medicare as well as input.
02/12/2019	<ul style="list-style-type: none"> Version 18. Annual Review. Updates based on input.
08/19/2019	<ul style="list-style-type: none"> Version 19. Mid-Term Review.

ⁱ The Mississippi Medicaid Provider Reference Guide defines “Serious Emotional Disturbance” as a diagnosable mental disorder found in youth that is so severe and long lasting that it seriously interferes with functioning in family, school, community or other major life activities, Public Law 102-321 states that: “The resulting definition of SED requires children to have a psychiatric diagnosis (excluding V codes, substance abuse, and developmental disorders occurring in the absence of another diagnosable disorder) and substantial impairment in family, school or community activities. Adding an impairment indicator was meant to distinguish between children with psychiatric disorders that significantly affected their ability to function in their environment and those having only mild impairments.”

ⁱⁱ The Mississippi Medicaid Provider Reference Guide defines “Serious Emotional Disturbance” as a diagnosable mental disorder found in youth that is so severe and long lasting that it seriously interferes with functioning in family, school, community or other major life activities, Public Law 102-321 states that: “The resulting definition of SED requires children to have a psychiatric diagnosis (excluding V codes, substance abuse, and developmental disorders occurring in the absence of another diagnosable disorder) and substantial impairment in family, school or community activities. Adding an impairment indicator was meant to distinguish between children with psychiatric disorders that significantly affected their ability to function in their environment and those having only mild impairments.”