



United Behavioral Health

Supplemental Clinical Criteria: Minnesota Medica Medicaid

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INTRODUCTION & INSTRUCTIONS FOR USE

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

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

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

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

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

² **Clinical Criteria**

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

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

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

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

³ Optum is a brand used by United Behavioral Health and its affiliates.

EVIDENCE-BASED PRACTICE CRITERIA

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

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

ADULT REHABILITATION MENTAL HEALTH SERVICES

ADULT REHABILITATIVE MENTAL HEALTH SERVICES ARMHS are a set of services developed to bring restorative, recovery-oriented interventions directly to individuals who have the capacity to benefit from them, whether in their homes or elsewhere in the community. This means that skills that have been lost or diminished due to the symptoms or mental illness can be acquired, practiced, and enhanced whenever and wherever they are needed.

ARMHS includes seven components:

- **Basic Living and Social Skills:** skills fostered one-on-one or in a group setting that are aimed at improving an individual's ability to live independently.
- **Certified peer specialist services:** Non-clinical, recovery-focused activities encouraging empowerment, self-determination, and decision-making, which are only provided by a CPS Activities that can address and contribute to the ARMHS team insights about feelings associated with stigma, social isolation, personal loss, systemic power dynamics and restoring one's lifestyle following hospitalization, or other acute care services.
- **Community Intervention:** strategies aimed at reducing barriers to integration in the community, independent living, or securing community living when symptoms of mental

illness have become unmanageable. These strategies minimize the risk of loss of community living which could result in the loss of a job, eviction, hospitalization.

- Functional assessment: The billable service of an FA includes the functional and LOCUS assessments, and the interpretive summary. A comprehensive FA is a narrative that describes how the person's mental health symptoms impact their day-to-day functioning in a variety of roles and settings. It is important to look at how factors other than mental health symptoms impact life functioning.
- Individual treatment plan: An individual treatment plan (ITP) is a written plan that documents the treatment strategy, the schedule for accomplishing the goals and objectives, and the responsible party for each treatment component. Development of the ITP includes involvement of the client, client's family, caregivers or other people, which may include people authorized to consent to mental health services for the client, and includes arrangement of treatment and support activities consistent with the client's cultural and linguistic needs. Give a copy of the approved plan to the member or guardian.
- Medication Education: information which teaches individuals about mental illness and its symptoms, as well as the role of prescription medication and its effects/side effects.
- Transitioning to Community Living: services provided to an individual who will be leaving sub-acute care (e.g., Assertive Community Treatment) or acute care (e.g., Residential Treatment Center, Inpatient). These services allow collaboration between the rehabilitation service provider and the sub-acute/acute care provider in support of the individual's successful transition into community living.

Admission Criteria

- The member is age 18 or older,
AND
- The member has received a diagnostic assessment by a qualified mental health professional,
AND
- Has a primary diagnosis of a serious mental illness,
• AND
- The following indicates that ARMHS is medically necessary:
 - The member has substantial disability and functional impairment, per the Functional Assessment in three or more areas, thus markedly reducing self-sufficiency.
 - Areas of functional impairment include:
 - Communicating opinions, thoughts and feelings, or key information to others;
 - Feeling confident in different social roles and settings;
 - Communicating about, or when in a stressful situation;
 - Discovering and using community resources to get needs met;
 - Getting outside help to deal with a difficult situation;
 - Preventing relapse;
 - Budgeting and shopping;
 - Developing a healthy lifestyle;
 - Learning to cook and eat a healthy diet;
 - Learning to get around the community;
 - Monitoring use and effectiveness of medications;
 - Managing the symptoms of mental illness;
 - Managing a household;
 - Finding and retaining a job;
 - Planning for employment;
 - Pursuing education;
 - Re-entering community living after treatment.
- AND
- The member has the cognitive capacity to engage in and benefit from rehabilitative services techniques and methods.
AND
- The provider uses the Level of Care Utilization System (LOCUS) to conduct a functional assessment, and the LOCUS supports the need for Level 2 or 3 services.
AND
- The member's condition can be safely managed in an ambulatory setting. Examples include:

- Imminent or current risk of harm to self or others, and/or property, if present, does not require 24-hour care;
- The member's primary behavioral health condition or co-occurring medical and behavioral health conditions do not require 24-hour care.
- Services can be provided in the following settings:
 - A member's home
 - The home of a relative or significant other
 - A member's job site
 - Psychosocial clubhouse
 - Drop-in center
 - Social setting
 - School
 - Other place in the community

AND

- Services are medically necessary as indicated by the following:
 - The service is consistent with the member's diagnosis and condition; and
 - Is recognized as the prevailing standard or current practice by the provider's peer group;
 - Is rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for a mother and child through the maternity period; or to achieve a level of physical or mental function; or
 - Is a preventive health service.

Service Delivery

- Evaluation and Treatment Planning
 - A qualified mental health professional completes a diagnostic assessment within the following timeframes:
 - No more than 180 calendar days prior to the date of admission; or
 - Within 30 calendar days of admission; or
 - Within 5 calendar days of the second meeting following the date of admission; and
 - At least annually thereafter.
 - The provider completes a functional assessment using the LOCUS within the following timeframes:
 - No more than 30 calendar days prior to the date of admission; or
 - Within 30 calendar days of admission; and
 - At least once every 6 months thereafter.
 - The narrative portion of the functional assessment is updated more frequently because the member's abilities and functioning may change as a result of services.
 - The responsible provider in conjunction with the service team and, whenever possible, the member develops a multidisciplinary service plan that focuses on the following:
 - The member's rehabilitation goal;
 - The member's present level of skills and knowledge relative to the rehabilitation goal;
 - The skills and knowledge needed to achieve the member's rehabilitation goal;
 - The member's present resources and the resources needed to achieve the member's rehabilitation goal.
 - An individual treatment plan (ITP) is completed before mental health service delivery begins.
 - An ITP documents the plan of care and guides treatment interventions.
 - The ITP includes involvement of the client, client's family, caregivers or other people, which may include people authorized to consent to mental health services for the client, and includes arrangement of treatment and support activities consistent with the client's cultural and linguistic needs.
 - When completing the ITP for adults, the following components must be present on the plan:
 - Cultural considerations, as related to service plan and delivery
 - A list of functional barriers to be addressed in the plan
 - Strength and resources that are a benefit in this time of change

- Referrals to be pursued, if any
 - Information about service coordination that identifies the following:
 - Other service providers
 - The service
 - Frequency and form of routine contact between ARMHS and other providers.
- Additional requirements for the ITP include:
 - Recovery vision in member's own words
 - Goals
 - Objectives
 - Interventions
 - A proposed timeline for completion
 - Identified skills or skill set to be learned, mastered or generalized
 - Where the intervention will take place
 - Description of the type of rehabilitative intervention to be used such as demonstrating, modeling, showing or practicing
 - Type of service method, one-on-one or group
 - Length of typical session
 - Frequency of session
 - Timeframes for rehabilitative objectives and interventions
 - Service category: Basic living and social skills (BLSS), medication education (ME), community intervention (CI), transition to community living (TCL) or certified peer specialist (CPS)
 - The member must sign and receive a copy of the ITP
 - The mental health professional and mental health practitioner under the clinical supervision of a mental health professional must sign the ITP.
- Best practice is that the service plan includes short term and long term goals where short term goals are attainable in 30-90 calendar days.
- The service plan includes specific and measurable objectives aimed at assisting the member with achieving the rehabilitation goal, and interventions for each skill, knowledge, or resource objective.
- The service plan is informed by the findings of the diagnostic evaluation and the functional assessment.
- Service plans should be reviewed as frequently as needed, but at a minimum every 90 calendar days.
- When the diagnostic evaluation or functional assessment identifies potential risk of harm to self, others, and/or property, a 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.

AND

- Discharge Planning
 - Discharge planning is initiated as soon as appropriate after the onset of ARMHS. As part of discharge planning, the provider solicits input from the member/member's parent or guardian, service providers and significant others.
 - Discharge planning anticipates the effects of termination in order to ensure a seamless transition from ARMHS.
 - Discharge planning also takes into consideration:
 - The reason that ARMHS is being terminated.
 - Providing the member with reasonable notice that services are ending.
 - Identifying the member's progress meeting their goals.
 - Identifying the services and supports needed to further assist the member with optimizing functioning and remaining in his/her community.
 - For members remaining in the program's geographic area of responsibility, the provider:
 - Shares the results of discharge planning and all pertinent information with other providers delivering services to the member prior to discharge.

- Provides the member with information about:
 - a. Recommended self-help and community resources; and
 - b. How the member can resume ARMHS.
- For members moving outside the program's geographic area of responsibility, the provider discusses the need for and availability of ARMHS with the member. As needed, the provider assists the member with accessing ARMHS in the member's new service area. The case manager maintains contact with the member through the transition.

CHILDREN'S THERAPEUTIC SUPPORT SERVICES

CTSS is a flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. CTSS addresses the conditions of emotional disturbance that impair and interfere with an individual's ability to function independently. For children with emotional disturbances, rehabilitation means a series or multidisciplinary combination of psychiatric and psychosocial interventions to:

- Restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or
- Enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills, deficits or maladaptive skills acquired over the course of a psychiatric illness.

Psychiatric rehabilitation services for children combine psychotherapy to address internal psychological, emotional and intellectual processing deficits with skills training to restore personal and social functioning to the proper developmental level. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over time. CTSS services are delivered using various treatment modalities and combinations of services designed to reach measurable treatment outcomes identified in an individual treatment plan (ITP).

CTSS includes the following services:

- Psychotherapy (individual, family, and group)
- Skills training (individual, family, and group)
- Crisis assistance
- Mental health behavioral aide
- Direction of mental health behavioral aide

In addition, providers may be certified to provide:

- CTSS day treatment
- Mental health behavioral aide service

Admission Criteria

- The member has had a diagnostic assessment within 180 calendar days before the request or referral. The member has received a diagnostic assessment from a qualified behavioral health professional, and meets any of the following criteria:
 - Under age 18 and is diagnosed with an Emotional Disorder as indicated by an organic disorder of the brain or clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.
 - Under age 18 and is diagnosed with a Severe Emotional Disturbance as indicated by at least one of the following:
 - The member has been admitted for inpatient or residential treatment within the last three years or is at risk of being admitted.
 - The member is a resident of Minnesota and is receiving inpatient or residential treatment for a behavioral health condition through the interstate compact.
 - A behavioral health professional has determined that the member meets one of the following criteria:
 - The member has psychosis or clinical depression;

- The member is at risk of harm to self or others as a result of a behavioral health condition;
- The member has psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year;
- A behavioral health professional has determined that the member has significantly impaired home, school or community functioning lasting at least one year or there is risk that impaired functioning will last at least one year.
- Be under 21 years old;
- Have a diagnostic assessment that documents:
 - A primary diagnosis of an emotional disturbance for children under 18 years old or mental illness for young adults 18 through 20 years old
 - Medical necessity for CTSS
 - A completed CASII or ECSII
 - Between ages 18 through 20 and is diagnosed with mental illness or Serious and Persistent Mental Illness.
 - Serious and Persistent Mental Illness is indicated by the presence of a mental illness and at least one of the following:
 - The member has undergone two or more episodes of inpatient care within the preceding 24 months;
 - The member has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the previous 12 months;
 - The member has been treated by a crisis team two or more times within the preceding 24 months;
 - The member has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder; significant impairment in functioning; and has a written opinion from a behavioral health professional stating he or she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided;
 - The member has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued;
 - The member was eligible under one of the above criteria, but the specified time period has expired;
 - The member was eligible as a child with severe emotional disturbance, and the member has a written opinion from a mental health professional, in the last three years, stating that he or she is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria, unless ongoing case management or community support services are provided.

AND

- The member's condition can be safely managed in an ambulatory setting. Examples include:
 - Imminent or current risk of harm to self or others, and/or property, if present, does not require 24-hour care;
 - The member's primary behavioral health condition or co-occurring medical and behavioral health conditions do not require 24-hour care.

AND

- Services are medically necessary as indicated by the following:
 - The service is consistent with the member's diagnosis and condition; and
 - Is recognized as the prevailing standard or current practice by the provider's peer group;
 - Is rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for a mother and child through the maternity period; or to achieve a level of physical or mental function; or
 - Is a preventive health service.

Service Delivery

- Evaluation and Treatment Planning
 - A qualified mental health professional completes a diagnostic assessment no more than 180 calendar days prior to the date of admission.
 - Diagnostic assessments for children under age 6 are typically interactive, and may employ the use of physical aids and nonverbal communication when the child has not yet developed, or has lost expressive communication skills needed to explain his/her symptoms and response to treatment; or does not possess the receptive communication skills needed to understand the provider via ordinary adult language.
 - For children assessing for functioning should be automatic in a diagnostic assessment. Functional assessment is present in every aspect of the assessment process, based on the recognition that a child's developmental progress in all areas (physiological, cognitive, emotional, and relational) determines the expected level of a child's functioning.
 - The provider completes a functional assessment using the Child and Adolescent Intensity Instrument (CASII) and the Strengths & Difficulties Questionnaire (SDQ) for children ages 6-18, and the Early Childhood Service Intensity Instrument (ECSII) and the SDQ for children under 6 years old. These tools are used to gauge level of functioning over time.
 - The CASII and SDQ are administered at intake, every 6 months thereafter and at discharge;
 - The ECSII and SDQ are administered at intake, every 3 months thereafter and at discharge.
 - All services under CTSS must have an individual treatment plan prior to the start of service. The plan must be reviewed at a minimum every 90 calendar days.
 - The plan focuses on the member's vision of recovery and resilience, and documents the treatment strategy, the schedule of accomplishing the goals and objectives, and the responsible party for each treatment component.
 - The plan provides the member and family with a clear understanding of the services to be offered and how they will address the member's needs. Consequently, the member/member's parent or guardian takes part in developing the plan.
 - The plan must be achievable and based on the member's diagnosis and standards of practice for behavioral health treatment for people with that diagnosis. The objectives must be incremental and measurable. The ultimate goal is to reduce the duration and intensity of symptoms and services to the least intrusive level possible.
 - a. Best practice is that the service plan includes short term and long term goals where short term goals are attainable in 30-90 calendar days.
 - The plan for a child or adolescent:
 - a. Includes the member's/parent or guardian's expectations to help guide treatment planning and selection.
 - b. Reviews with the member/parent or guardian their understanding of concerns and the collaborative treatment process.
 - c. Includes mutually defined, comprehensible terms.
 - d. Addresses the member's strengths and vulnerabilities.
 - e. Indicates areas of uncertainty and makes recommendations on further assessments.
 - f. Communicates with the referring clinician, agencies, pediatricians, and schools (with parental consent).
 - g. Helps the member/parent or guardian identify services and facilitates referrals.
 - The plan for Mental Health Behavioral Aide (MHBA) requires the following steps:
 - a. A behavioral health professional must approve services to be provided by a MHBA.

- b. A behavioral health professional collaborates with the member's family, via parent teaming, to account for the needs of the child and family. The scope, duration, and frequency of services are considered.
 - If a member is receiving MHBA services, and individual behavior plan is required in addition to the treatment plan. The behavior plan is a written plan of MHBA services developed by a behavioral health professional that includes detailed instructions for the aide on the services to be provided. It must also include:
 - Time allocated to each service;
 - Methods of documenting the member's behavior;
 - Methods of monitoring the child's progress in reaching objectives;
 - Goals to increase or decrease target behavior as identified in the treatment plan.
 - Best practice is that the treatment plan includes short term and long term goals where short term goals are attainable in 30-90 calendar days.
 - The treatment plan includes specific and measurable objectives aimed at assisting the member with achieving the treatment goal, and interventions for each skill, knowledge, or resource objective.
 - The treatment plan is informed by the findings of the diagnostic evaluation and the functional assessment.
 - Service plans should be reviewed as frequently as needed, but at a minimum every 90 calendar days.
 - When the diagnostic evaluation or functional assessment identifies potential risk of harm to self, others, and/or property, a safety plan is completed that includes:
 - Triggers;
 - Current coping skills;
 - Warning signs;
 - Preferred interventions;
 - Advance directives for adults receiving CTSS, when available.
 - The program provides an effective system for reaching out to members who are not attending, becoming isolated, or who are hospitalized.
- Discharge Planning
 - Discharge planning is initiated as soon as appropriate after the onset of CTSS. As part of discharge planning, the provider solicits input from the member/member's parent or guardian, service providers and significant others.
 - Discharge planning anticipates the effects of termination in order to ensure a seamless transition from CTSS.
 - Discharge planning also takes into consideration:
 - The reason that CTSS is being terminated.
 - Providing the member with reasonable notice that services are ending.
 - Identifying the member's progress meeting their goals.
 - Identifying the services and supports needed to further assist the member with optimizing functioning and remaining in his/her community.
 - For members remaining in the program's geographic area of responsibility, the provider:
 - Shares the results of discharge planning and all pertinent information with other providers delivering services to the member prior to discharge.
 - Provides the member with information about:
 - Recommended self-help and community resources; and
 - How the member can resume CTSS.
 - For members moving outside the program's geographic area of responsibility, the provider discusses the need for and availability of CTSS with the member. As needed, the provider assists the member with accessing CTSS in the member's new service area. The case manager maintains contact with the member through the transition.

TARGETED CASE MANAGEMENT

MENTAL HEALTH TARGETED CASE MANAGEMENT Adult mental health targeted case management (AMH-TCM) and children's mental health targeted case management (CMH-TCM) services help adults with serious and persistent mental illness (SPMI) and children with severe emotional disturbance (SED) gain access to medical, social, educational, vocational and other necessary services connected

to the person's mental health needs. Targeted case management (TCM) services include developing a functional assessment (FA) and individual community support plan (ICSP) for an adult and an individual family community support plan (IFCSP), referring and linking the person to mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Case management services involve:

- Developing a functional assessment and individual community support plan;
- Referring and assisting the member with obtaining needed mental health and other services;
- Ensuring coordination of services; and
- Monitoring the delivery of services.

Admission Criteria

- The member has had a diagnostic assessment within 180 calendar days before the request or referral for case management services and the diagnostic assessment has determined that the member is eligible.

AND

- Notwithstanding this requirement, a member is eligible for case management services if all of the following criteria are met:
 - The member requests or is referred for and accepts case management services.
 - A diagnostic assessment is refused.
 - The case manager determines that the person is a child with Severe Emotional Disturbance or an adult with a Serious and Persistent Mental Illness.
 - The member obtains a diagnostic assessment within 4 months of the day the member first receives case management services.

AND

- **Adults**

- Age 18 or older and either of the following:
 - Member has a Serious and Persistent Mental Illness as indicated by at least one of the following:
 - Two or more episodes of inpatient care for a mental health condition within the past 24 months;
 - Continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the past 12 months;
 - Treatment by a crisis team two or more times within the past 24 months;
 - A diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, major depression or borderline personality disorder which causes significant functional impairment; a mental health professional has submitted a written opinion stating that the member is likely to require inpatient or residential treatment unless community support program services are provided;
 - In the last three years a court has committed the member as a mentally ill person under Minnesota statutes, or a commitment has been stayed or continued;
 - The person was eligible under one of the above criteria; but the specified time period has expired;
 - The member is determined by a county or tribe to appear eligible for case management but due to the person's initial refusal to participate in the diagnostic assessment, the member's eligibility determination can't be completed; eligibility is limited to 90 calendar days.

OR

- **Children and Adolescents**

- Under age 18 and the member has a Severe Emotional Disturbance as indicated by at least one of the following:
 - The member has been admitted for inpatient or residential treatment within the last three years or is at risk of being admitted.
 - The member is a resident of Minnesota and is receiving inpatient or residential treatment for a behavioral health condition through the interstate compact.
 - A mental health professional has determined that the member meets one of the following criteria:

- The member has psychosis or clinical depression;
- The member is at risk of harm to self or others as a result of a behavioral health condition;
- The member has psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year;
- A behavioral health professional has determined that the member has significantly impaired home, school or community functioning lasting at least one year or there is risk that impaired functioning will last at least one year.
- An adolescent who has received MH-TCM services within 90 days prior to turning 18 may qualify for AMH-TCM.

AND

- **All Members**

- The member requires assistance accessing needed medical, social, educational, vocational, financial and other necessary services as they relate to individual's mental health needs.

AND

- The member's condition can be safely managed in an ambulatory setting. Examples include:
 - Imminent or current risk of harm to self or others and/or property, if present, does not require 24-hour care;
 - The member's primary behavioral health condition or co-occurring medical and behavioral health conditions do not require 24-hour care.

AND

- Services are medically necessary as indicated by the following:
 - The service is consistent with the member's diagnosis and condition; and
 - Is recognized as the prevailing standard or current practice by the provider's peer group;
 - Is rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for a mother and child through the maternity period; or to achieve a level of physical or mental function; or is a preventive health service.

Discharge Criteria

- A mental health professional who has provided behavioral health services to the member furnishes a written opinion that the member no longer meets the eligibility criteria.
OR
- The member/member's parent or guardian and the case manager decide that the member no longer requires case management services.
OR
- The member/member's parent or guardian refuse further case management services.
OR
- The member is not in a residential treatment facility, regional treatment center, or acute care hospital in a county outside the county of financial responsibility; no face-to-face contact has occurred between the case manager and the member because the member has failed to keep an appointment or refused to meet with the member.
- **Adults:** no face-to-face contact has occurred for 180 consecutive calendar days.
- **Children and Adolescents:** no face-to-face contact has occurred for 90 consecutive calendar days.
OR
- Continued stay criteria are otherwise no longer met.

Service Delivery

- Evaluation and Treatment Planning
 - Within 30 calendar days after first meeting with the member, the case manager:
 - Reviews the diagnostic assessment.

- Assesses the member's strengths, resources, supports, needs, functioning, health problems and conditions, safety, vulnerability, and injury risk. The assessment includes the member's family and other natural resources whenever possible.
- Screens for drug and alcohol use.
- Reviews documentation of the member's status, cultural considerations, and functional status in the following domains:
 - a. Behavioral health symptoms and needs as presented in the diagnostic assessment;
 - b. Use of drugs and alcohol;
 - c. Vocational and educational functioning;
 - d. Social functioning, including use of leisure time;
 - e. Interpersonal functioning, including relationships with the member's family;
 - f. Self-care and independent living capacity;
 - g. Medical and dental health;
 - h. Financial assistance needs;
 - i. Housing and transportation needs; and
 - j. Other needs and problems.
- For adult members, completes the LOCUS to determine resources and resource intensity needs.
- Develops a support plan in collaboration with the member/member's parent or guardian that includes:
 - The member's goals and the specific services;
 - Activities for accomplishing each goal;
 - Schedule for each activity;
 - Frequency of face-to-face contact with the case manager occurring at least monthly except for limited situations such as less frequent contact prior to terminating case management as part of determining the aptness of case closure.
- The case manager's interactions with the member/member's parent or guardian include the following which are aimed at helping the member acquire resources in support of the member's goals:
 - Connect the member with informal natural supports;
 - Link the member with the local community, resources, and service providers;
 - Refer the member to available health treatment and rehabilitation services.
 - The case manager collaborates with the member/member's parent or guardian, other providers, resources, and service representatives to:
 - a. Ensure service coordination by reviewing programs and services for accountability, verification that everyone is addressing the same purposes stated in the service plan so that the member is not exposed to discontinuous or conflicting interventions and services.
 - b. Determine achievement of goals/objectives in the member's service plan to see if goals are being achieved according to the service plan's projected timelines and continue to fit the recipient's needs.
 - c. Determine service and support outcomes through ongoing observations which can trigger reconsideration of the plan and its recommended interventions when the service plan is not accomplishing its desired effects.
 - d. Identify emergence of new needs by staying in touch with the member to identify problems, modify plans, ensure the recipients has resources to complete goals, and track emerging needs.
- The case manager reviews, and if necessary revises, the support plan at least every 180 calendar days, and at the same time reviews the member's functional assessment. The support plan may be reviewed more frequently such as when:
 - The member's service needs change;
 - The member/member's parent or guardian requests that the service plan be reviewed every 90 calendar days.
- Discharge Planning

- Discharge planning is initiated as soon as appropriate after the onset of case management. As part of discharge planning, the case manager solicits input from the member/member's parent or guardian, service providers and significant others.
- Discharge planning anticipates the effects of termination in order to ensure a seamless transition from case management.
- Discharge planning also takes into consideration:
 - The reason that case management is being terminated.
 - Providing the member with reasonable notice that services are ending.
 - Identifying the member's progress meeting their case management goals.
 - Identifying the services and supports needed to further assist the member with optimizing functioning and remaining in his/her community.
- For members remaining in the program's geographic area of responsibility, the case manager:
 - Shares the results of discharge planning and all pertinent information with other providers delivering services to the member prior to discharge.
 - Provides the member with information about:
 - Recommended self-help and community resources; and
 - How the member can resume case management.
- For members moving outside the program's geographic area of responsibility, the case manager discusses the need for and availability of case management with the member. As needed, the case manager assists the member with accessing case management in the member's new service area. The case manager maintains contact with the member through the transition.

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REVISION HISTORY

Date	Action/Description
July, 2016	• Version 1
September, 2017	• Version 2
October, 2018	• Version 3-Annual Review
November, 2019	• Version 4-Annual Review; updated references, formatting, added Evidence-Based Criteria Section