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 managed by Optum®.

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

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

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

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

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

COMMON CRITERIA

Admission Criteria

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1 Optum is a brand used by United Behavioral Health and its affiliates.
• The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
  o Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.
  o 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.

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 managed in the proposed level of care.
AND

• Services are medically necessary.
AND

• For all levels of care, services must be for the purpose of diagnostic study or reasonably be expected to improve the patient’s condition. The treatment must, at a minimum, be designed to reduce or control the patient’s psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient’s level of functioning.
  o 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.
  o 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:
  o Supervised and evaluated by the admitting provider;
  o Provided under an individualized treatment plan consistent with Common Clinical Best Practices;
  o Reasonably expected to improve the member’s presenting problems.

AND

• The factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

• Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.

AND

• The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated and feasible.

Discharge Criteria

• The continued stay criteria are no longer met. Examples include:
  o The member’s condition no longer requires care.
The member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.

The member requires medical/surgical treatment.

After an initial assessment the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

### COMMON CLINICAL BEST PRACTICES

#### Introduction

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

#### Evaluation & Treatment Planning

- **The initial evaluation:**
  - Gathers information about the presenting issues from the member’s perspective, and includes the member’s understanding of the factors that lead to requesting services;
  - Focuses on the member’s specific needs;
  - Identifies the member’s goals and expectations;
  - Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

- **The provider collects information 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 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.

**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 four 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.
- **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.
- **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**

- See Common Criteria
- The member is age 18 or older.
- The member has received a diagnostic assessment by a qualified mental health professional, and the following indicates that ARMHS is medically necessary:
  - The member has substantial disability and functional impairment 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.
- The member has the cognitive capacity to engage in and benefit from rehabilitative services techniques and methods.
- 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.
- 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 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.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Best Practices

AND

- 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.
  - 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)**

**CHILDREN’S THERAPEUTIC SUPPORT SERVICES (CTSS)** CTSS is designed to help children with significant impairments in their functional abilities at home and in the community that result from a mental health disorder. CTSS includes different levels of rehabilitative interventions intended to restore the individual to normally expected levels of functioning. CTSS may require collaboration among providers or agencies to ensure that goals and methods are aligned.

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

**Admission Criteria**
- See Common Criteria AND
- 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, or clinical trainee 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.
  - 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.

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria
Clinical Best Practices

- See Common Best Practices
  AND
- Evaluation and Treatment Planning
  
  o A qualified mental health professional or a clinical trainee 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.
    o The provider or clinical trainee 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.
  
  o 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, an 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.
MENTAL HEALTH TARGETED CASE MANAGEMENT  MH-TCM is intended to help members gain access to needed medical, social, educational, vocational, financial and other necessary services as they relate to a member’s mental health needs. Case management support is provided to adults with Serious and Persistent Mental Illness (SPMI), and children/adolescents with Severe Emotional Disturbance (SED).

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
- See Common Criteria
AND
- 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.

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.

**Continuing Stay Criteria**

- See Common Criteria

**Discharge Criteria**

- See Common Criteria
  - AND
  - 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.

**Clinical Best Practices**

- See Common Best Practices
  AND
  
**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:
    - Behavioral health symptoms and needs as presented in the diagnostic assessment;
    - Use of drugs and alcohol;
    - Vocational and educational functioning;
    - Social functioning, including use of leisure time;
    - Interpersonal functioning, including relationships with the member’s family;
    - Self-care and independent living capacity;
    - Medical and dental health;
    - Financial assistance needs;
    - Housing and transportation needs; and
    - 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:
      - 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.
      - 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.
      - 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.

REFERENCES

Common Criteria and Common Clinical Best Practices


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


**Adult Rehabilitation Mental Health Services**


**Children’s Therapeutic Support Services**


**Targeted Case Management**


9520 MS. Sec. 0905. Outcomes of Case Management Services to Adults with Serious and Persistent Mental Illness.


**REVISION HISTORY**

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<thead>
<tr>
<th>Date</th>
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<tbody>
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</tr>
<tr>
<td>September, 2017</td>
<td>• Version 2</td>
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<td>October, 2018</td>
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