United Behavioral Health

New Jersey 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 managed by Optum®.

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. 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 supersedes this guideline when required to do so by contract or regulation.

COMMON CRITERIA

Admission Criteria

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 form 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.
  o When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
  o 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:
  o An appropriate discharge plan is in place prior to discharge;
  o The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
  o The member agrees with the discharge plan.

• For members continuing treatment:
  o 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:
  o 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.

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**ADULT MENTAL HEALTH REHABILITATIVE SERVICES**

AMHR provides services in/by a licensed community residence. Services include, but are not limited to, the following:
• Assessment and evaluation
• Individual services coordination
• Training in daily skills
• Residential counseling
• Support services
• Crisis intervention counseling services
• Medication education and facilitation of proper administration techniques
• Health care monitoring and oversight services

The goal of AMHR is to support and encourage the development of life skills required to sustain successful living in the least restrictive environment within the community.

Levels of AMHR are:

• Supervised Residence A+ - refers to licensed group homes or apartments. Community mental health rehabilitation services are available 24 hours per day, seven days a week. This includes awake overnight staff coverage.
• Supervised Residence A – refers to licensed group homes or apartments. Community mental health rehabilitation services are available 12 hours or more per day, but less than 24 hours per day, seven days a week.
• Supervised Residence B – refers to licensed group homes or apartments. Community mental health rehabilitation services are available for 4 or more hours per day, but less than 12 hours per day, seven days per week.
• Supervised Residence C – refers to licensed group homes or apartments. Community mental health rehabilitation services are available for one or more hours per week, but less than 4 hours per day.
• Family Care (Level D) – refers to a licensed program in a private home or apartment in which community mental health rehabilitation services are for 24 hours per day by a Family Care Home provider.

Admission Criteria

• See Common Criteria
AND
AND
• The member is 18 years or older and has been diagnosed with a Serious Mental Illness that seriously impairs the member's capacity to live independently with appropriate supports as needed.
• The member is referred to AMHR by a licensed professional of the healing arts, including physicians.
• The member does not have an acute medical condition requiring inpatient hospitalization, does not need nursing home level of care, is able to evacuate the residence within 3 minutes, and is capable of managing incontinence and other medical care needs.
• Services are medically necessary.

Continuing Stay Criteria

• See Common Criteria

Discharge Criteria

• See Common Criteria
OR
• Any of the following conditions are met:
  • The member creates a substantial, continuing and immediate threat to the physical safety or other persons, or to the emotional or psychological health of other residents; provided, however, that the Provider Agency shall not discharge the member on this basis if the person has been civilly committed.
The Provider Agency reasonably concludes that the member’s clearly inappropriate behavior renders the program out of compliance with any agreement to which the Provider Agency is signatory as a lessee or with any applicable law or regulation.

The member repeatedly violates a rule governing resident conduct, which is reasonable both in itself and its application, after the Provider Agency delivers to the member a written notice to cease violating such rule. No such rule shall be the basis for discharging a person unless it is reflected in a resident services agreement and/or other documents in compliance with these rules.

The member has received maximum clinical benefit of the services offered by the Provider Agency, an appropriate alternative living arrangement (where the person has sufficient financial resources), other than a shelter, motel or hospital, is available to the member prior to discharge, and the program reasonably determines that discharge would be in the member’s best clinical interests.

The member is absent from the residence for a continuous period of thirty (30) days without providing the Provider Agency with notice of intent to return after the expiration of the 30-day period; provided, however, that continued absence beyond 30 days shall be a condition for discharge if such absence is not in the member’s clinical best interest.

The member has refused necessary and appropriate services offered by the Provider Agency pursuant to a properly developed treatment plan; the refusal is contrary to the member’s clinical best interest; the member has failed to offer any alternative plan which would be consistent with the member’s clinical interest; and an alternative living arrangement other than a hospital is available.

Clinical Best Practices

- See Common Best Practices

- A written comprehensive rehabilitation needs assessment for each consumer by the 14th day after admission.

- A nursing assessment is also completed within the first 14 calendar days. The assessment justifies the need for AMHR and recommends an appropriate level of service.

- The initial nursing assessment shall be used in conjunction with the comprehensive intake assessment to develop the comprehensive service plan.

- No later than 30 days after the consumer has been admitted, staff partner with the consumer to develop, implement, monitor, and update an individualized rehabilitation plan.

- Review of the individualized rehabilitation plan shall occur as follows:
  - A consumer may request a review and/or revision of the individualized rehabilitation plan at any time.
  - In addition to any request by the consumer, staff shall review and, as necessary, revise the individualized rehabilitation plan within 3 months of its development and every 3 months thereafter.

- A registered nurse or higher level nursing professional shall provide face-to-face nursing visits every 90 days following the initial comprehensive nursing assessment while the consumer resides in a supervised residence and shall document such visits in the consumer’s progress notes. In addition, where necessitated by the consumer’s needs, a registered nurse or higher level nursing professional shall visit the consumer to periodically evaluate the consumer’s condition and the appropriateness of care provided by staff. These 90-day visits shall include an assessment and review of the consumer’s clinical condition, which shall assure that services are being provided consistent with the consumer’s individualized rehabilitation plan.

PARTIAL CARE SERVICES

PARTIAL CARE is an individualized, outcome-oriented mental health service, which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program in a community setting to assist members who have serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives. Partial care services are offered to an individual age 18 or older with a primary psychiatric disorder that is accompanied by an impaired ability to perform living, learning, working or social roles. Partial care services support consumer stabilization and community integration and are alternatives to more
intensive acute interventions. Partial care services provide active treatment and psychiatric rehabilitation for consumers who do not require inpatient hospitalization but require support and structured programming.

Partial Care Services assist members achieve community integration through valued living, learning, working, and social roles and to prevent hospitalization and relapse. The role of Partial Care is to facilitate the member’s integration and maintenance in the community. A balance between recovery oriented and clinical services is provided to members in a comprehensive individualized manner. This involves non-residential, structured programming which provide, but are not limited to counseling, case management, psychoeducation, prevocational services, social and leisure services, and psychiatric services. Services are available on an hourly basis for up to five (5) hours a day at least five (5) times per week.²

**Admission Criteria**

- See Common Criteria
  AND
- The member is diagnosed with a severe and persistent mental illness such as
  - Schizophrenia or other Psychotic Disorders
  - Major Depressive Disorder
  - Bipolar Disorder
  - Delusional Disorder
  - Schizoaffective Disorder
  - Affective Disorders
  AND
- The member demonstrates impaired functioning that leads to a need to learn critical skills in order to achieve a valued community role and integration in at least one of the following areas on a continuing and intermittent basis for at least one year:
  - Personal self-care;
  - Interpersonal relationships
  - Work
  - School
  - Ability to live in the community; or
  - Ability to acquire and/or maintain safe, affordable housing and is at risk of requiring a more restrictive living situation.
  AND
- The member is 18 years of age or older.
  AND
- There is clinical evidence to justify the necessity for partial care services. This necessity must be confirmed by the psychiatrist or advanced practice nurse and interdisciplinary treatment team and documented in the record.
  AND
- There is a need for psychiatric rehabilitation and active treatment of no less than two hours and no more than 25 hours weekly.
  AND
- The member meets one of the following:
  - The member has had one or more contacts with a screening center or emergency service mental health program
  - Two or more admissions to an inpatient behavioral health program including short term care facilities; or
  - One psychiatric hospitalization of three months or longer.
  AND
- Services are medically necessary.iii

**Continuing Stay Criteria**

- See Common Criteria

² New Jersey Administrative Code, Title 10, Chapter 37, Partial Care Service Standards, September 17, 2018.
Discharge Criteria

- See Common Criteria

Exclusions

- A primary Substance Use Disorder diagnosis
- Imminent danger to self, others or property
- A primary Developmental Disorder diagnosis
- Current participation in a PACT program

Clinical Best Practices

- See Common Best Practices

AND

- An initial service plan shall be completed during the intake process. This plan shall address the consumer's immediate needs and concerns, with special attention to urgent presenting problems, to meet immediate needs for food, clothing, shelter and medication.
- The plan of care is designed to improve the member’s condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary.\(^3\)
- The plan of care is included in the member's records and consists of:
  - A written description of the treatment objectives including both the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives;
  - A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
  - The type of personnel that will be furnishing the services; and
  - A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.
- The plan includes the member’s self-stated overall goals related to chosen, valued roles and specific plans to achieve these roles, with target dates, including further in-depth and ongoing assessment in the identified areas.
- The plan includes a comment section under which the member states in his/her own words any concerns, agreements, or disagreements with either the development of or final service plan.
- Signatures are required on the plan of care from the member/responsible party; the clinician/provider and the physician/APN.
- The provider develops and maintains legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.
- The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

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.


\(^3\) New Jersey Division of Medical Assistance and Health Services Partial Care Requirements


**New Jersey Guidance**


State of New Jersey, Division of Medical Assistance and Health Services, Partial Care Requirements (April, 2017).

**REVISION HISTORY**

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<tr>
<td>January, 2019</td>
<td>Version 6-Added Partial Care Services guideline.</td>
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1 Per NJAC 10:10 “Serious Mental Illness” means individuals who are in psychiatric crisis, or have a designated diagnosis of mental illness under the Diagnostic and Statistical Manual of Mental Disorders (DSM), and whose severity and duration of mental illness result in substantial functional disability.

2 The New Jersey Division of Medical Assistance and Health Services defines “medically necessary services” as services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this contract.
Medically necessary services provided must be based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance.

In the case of pediatric enrollees, this definition shall apply with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter whether or not they are ordinarily covered services for all other Medicaid enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

The New Jersey Division of Medical Assistance and Health Services defines "medically necessary services" as services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this contract.

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