INTRODUCTION

The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing1 for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)).

The Level of Care Guidelines is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS’ National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The Level of Care Guidelines is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.

For more information on guiding principles for the Level of Care Guidelines and their development, approval, dissemination, and use, please see the Introduction to the Level of Care Guidelines, available at: www.providerexpress.com > Clinical Resources > Level of Care Guidelines.

Before using this guideline, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.

ADULT MENTAL HEALTH REHABILITATION SERVICES

ADULT MENTAL HEALTH REHABILITATION SERVICES (AMHR) AMHR provides services in/by a licensed community residence. Services include, but are not limited to, the following:

- Assessment and evaluation

1 The terms “recovery” and resiliency” are used throughout the Psychological and Neuropsychological Testing Guidelines. SAMHSA defines “recovery” as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines “resilience” as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines “recovery” as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.
• 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.

1. Admission Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":  
     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.  
     AND
   • The member is referred to AMHR by a licensed professional of the healing arts, including physicians.  
     AND
   • 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.  
     AND
   • Services are medically necessary.

2. Continued Service Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":  

3. Discharge Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":  
     OR
   • Any of the following conditions are met:
     o 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.
     o 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.
o 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.

o 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.

o 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.

o 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.

4. Clinical Best Practices

- see "Common Criteria and Best Practices for All Levels of Care":
- see "Psychosocial Rehabilitation Clinical 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:
  o A consumer may request a review and/or revision of the individualized rehabilitation plan at any time.
  o 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.

REFERENCES*


*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines and in the related Behavioral Clinical Policy.
HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June, 2014</td>
<td>• Version 1</td>
</tr>
<tr>
<td>January, 2015</td>
<td>• Version 2</td>
</tr>
<tr>
<td>January, 2016</td>
<td>• Version 3</td>
</tr>
<tr>
<td>July, 2017</td>
<td>• Version 4</td>
</tr>
</tbody>
</table>

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.