United Behavioral Health

Supplemental Clinical Criteria: New Jersey 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.

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[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 GUIDELINES

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 MENTAL HEALTH REHABILITATION SERVICES

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

- The member is 18 years or older and has been diagnosed with a Serious Mental Illness[i] 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[ii].

Discharge Criteria

- 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.

Service Delivery

- 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.[4]

Admission Criteria

- The member is diagnosed with a severe and persistent mental illness such as
    - Schizophrenia or other Psychotic Disorders
    - Major Depressive Disorder
    - Bipolar Disorder

[4] New Jersey Administrative Code, Title 10, Chapter 37, Partial Care Service Standards, September 17, 2018.

    - 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 <u>one</u> 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].

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

Service Delivery

- 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[5].
- 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.

[5] New Jersey Division of Medical Assistance and Health Services Partial Care Requirements

- 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

State of New Jersey, Administrative Code. (2016). Chapter 10:10-1.3, Definitions.

State of New Jersey, Administrative Code. (2009). Chapter 37A, Community Residences for Mentally Ill Adults.

State of New Jersey, Administrative Code. (2018). Chapter 37F, Partial Care Services.

State of New Jersey, Administrative Code. (2012). Chapter 77A, Adult Mental Health Rehabilitation Services Provided in/by Community Residence Programs.

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

REVISION HISTORY

Date	Action/Description
June, 2014	Version 1
January, 2015	Version 2
January, 2016	Version 3
July, 2017	Version 4
October, 2018	Version 5
January, 2019	Version 6-Added Partial Care Services guideline.
January, 2020	Version 7- Updated Introduction & Instructions for Use; added Evidence-Based Practice Criteria section.

[i] 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.

[ii] 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.

[iii] 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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