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 benefits, the member’s specific benefits must be referenced.

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

- The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
  - Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.
  - 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.
  - 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.
  - 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:
  - Supervised and evaluated by the admitting provider;
Provided under an individualized treatment plan consistent with Common Clinical Best Practices;
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:
  - 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 BESTPRACTICES**

**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:
  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.

ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) refers to the evidence based model of delivering comprehensive community based behavioral health services to adults with certain serious and persistent mental illnesses who have not benefited from traditional outpatient treatment. The ACT model utilizes a multidisciplinary team of practitioners to deliver services to eligible individuals. The ACT team is the sole provider of outpatient behavioral health services, including Level 1 outpatient services as defined by the American Society of Addiction Medicine, to ACT members. ACT services include but are not limited to the following:

- Psychiatry and primary care,
- Service coordination,
- Crisis assessment and intervention,
- Symptom assessment and management,
- Community based rehabilitative services,
- Education, support, and consultation to families, legal custodians, and significant others who are part of the member's support network.

Admission Criteria

- See Common Criteria
- The member has a diagnosis of Schizophrenia, Bipolar, or Major Depressive Disorder with psychosis.
- The member has a score of two or greater on at least one of the items in the "mental health needs" or "risk behaviors" sections or a score of three on at least one of the items in the "life domain function" section of the adult needs and strengths assessment (ANSA) administered by an individual with a bachelor's degree or higher and with training in the administration of the assessment.
- The member has one or more of the following conditions:
  o Two or more admissions to a psychiatric inpatient hospital setting during the past twelve months or,
  o Two or more occasions of utilizing psychiatric emergency services during the past twelve months or,
  o Significant difficulty meeting basic survival needs including residing in substandard housing, homelessness, or imminent risk of homelessness or,
  o History within the past two years of criminal justice involvement including but not limited to arrest, incarceration, or probation,
  o And one or more of the following:
    ▪ Persistent or recurrent severe psychiatric symptoms including but not limited to affective, psychotic, or suicidal or,
    ▪ Coexisting substance use disorder of more than six month in duration or,
    ▪ Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided or,
    ▪ At risk of psychiatric hospitalization, institutional or supervised residential placement if more intensive services are not available or,
- Has been unsuccessful in using traditional office-based outpatient services.

AND
- The member is eighteen years of age or older at the time of ACT enrollment.

Continuing Stay Criteria
- See Common Criteria

Discharge Criteria
- See Common Criteria
AND
- A planned disenrollment from ACT occurs when a member or member's guardian and ACT team members mutually agree to the termination of ACT services and transition of the member to a different care setting, provider agency or benefit package. A planned disenrollment is appropriate when:
  - The member has successfully reached established goals for disenrollment and the member and/or their guardian and ACT team members agree to the discharge from ACT, or
  - The member moves outside the geographic area of the ACT team's responsibility.
    - In such cases, the ACT team arranges transfer of mental health and substance use disorder service responsibility to another ACT program or other provider wherever the member is moving. The ACT team maintains contact with the member until the transfer is complete, or
  - The member or their guardian declines or refuses services and requests a disenrollment, or
  - The member no longer meets the eligibility or medical necessity criteria for ACT.

- As part of a planned disenrollment, the ACT team documents that the member has actively participated in disenrollment activities by documenting in case notes the following information:
  - The reasons for the member's disenrollment as stated by both the member and the ACT team,
  - The member's functional status at disenrollment,
  - The member's progress toward the goals set forth in the treatment plan,
  - A post disenrollment treatment plan developed in conjunction with the member,
  - The signature of the member or their guardian, the ACT team leader, and the psychiatric prescriber.

- A member’s disenrollment from ACT may be unplanned and due to circumstances facilitated by:
  - The inability of the ACT team to locate the member for more than forty-five days, or
  - The member’s incarceration, hospitalization or admission to a residential substance use disorder treatment facility.
    - In these circumstances, the primary responsibility for the member’s health care is transferred to aforementioned setting.

AND
- The ACT team is expected to maintain contact with the member to assist with transition between settings if the member is likely to be discharged and resume service from the ACT team within two months.
AND
- If the member’s stay is predicted to be longer than two months, the member will be disenrolled from the ACT team.
AND
- The member may request reenrollment with the ACT team when discharged from the incarcerated, inpatient or residential setting. The member must meet admission criteria if there is a request for reenrollment.

Clinical Best Practices
- See Common Best Practices
AND
- Evaluation and Service Planning
The ACT team must develop a specific treatment plan for each enrolled member. The treatment plan must, at a minimum, meet the requirements of OAC 5122-27-03 plus the following additional requirements:

- The treatment plan is individualized based on the member’s needs, strengths, and preferences and sets measurable long-term and short-term goals and specify approaches and interventions necessary for the member to achieve the member goals. The treatment plan also identifies who will carry out the approaches and interventions.
- The treatment plan addresses, at a minimum, the following key areas:
  a. Psychiatric illness or symptom reduction.
  b. Stable, safe, and affordable housing.
  c. Activities of daily living.
  d. Daily structure and activities, including employment if appropriate.
  e. Family and social relationships.
  f. The treatment plan is reviewed and revised by a member of the ACT team with the member whenever there is a major decision point in the member's course of treatment or at least every six months.
  g. In conjunction with a treatment plan review, the ACT team member prepares a summary of the member's progress, goal attainment, effectiveness of the intervention and member's satisfaction with the ACT team interventions since enactment of the previous treatment plan.
  h. The treatment plan, and all subsequent revisions of it, are reviewed and signed or verbally agreed to by the member, the ACT team reviewer, and the ACT team leader.

Limitations and Exclusions

- The following services will not be covered as a part of ACT:
  o Time spent attending or participating in recreational activities.
  o Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
  o Habilitative services for the member to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
  o Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
  o Respite care.
  o Transportation for the member or family. Services provided in the vehicle are considered transportation and time may not be billed for ACT.
  o Services provided to children, spouse, parents, or siblings of the eligible member under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed in the eligible member's ACT treatment plan.
  o Art, movement, dance, or drama therapies.
  o Services provided to collaterals of the member.
  o Contacts that are not medically necessary.
  o Any service not identified on the member's ACT treatment plan unless otherwise prior authorized
  o Any service not in compliance with sections of this rule or the ACT fidelity standard.
  o Changes made to ACT service that do not follow the requirements or ACT fidelity standards referred to elsewhere in this rule.
  o Any intervention or contact not documented or consistent with the approved treatment plan goals, objectives, or approved services.
  o Vocational training and supported employment services unless the member is enrolled in the specialized recovery services program as defined in rule 5160-43-01 of the Administrative Code.
**BEHAVIORAL HEALTH NURSING**

Behavioral Health Nursing Services are those activities that are performed within professional scope of practice and in authorized settings by staff that are licensed by the Ohio board of nursing and are intended to address the behavioral and other physical health needs of individuals receiving treatment for psychiatric symptoms or substance use disorders. Activities may include performing health care screenings, nursing assessments and exams, checking vital signs, monitoring the effects of medication, symptoms, behavioral health education and collaboration with the individual and/or family as clinically indicated. Eligible Providers are Registered nurse (RN) as defined in and Licensed practical nurse (LPN) as defined in Ohio administrative code 5160-27-01.

**Admission Criteria**
- See Common Criteria

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Best Practices

**Limitations and Exclusions**
- Mental health nursing services are limited to 24 hours per calendar year. These limits can be exceeded with prior authorization.
- Substance use disorder nursing services are limited to 24 hours per calendar year. These limits can be exceeded with prior authorization.
- Group nursing services and nursing assessments must be provided by an RN.
- When behavioral health nursing services are provided medication administration will not be reimbursed when provided by the same practitioner, to the same recipient, on the same day.
- Behavioral health nursing services will not be reimbursed when a recipient is enrolled in ACT or in a SUD residential treatment facility.

**CHILDREN'S INTENSIVE BEHAVIORAL SERVICES**

**Children's Intensive Behavioral Services (CIBS)** include intensive services for children who have been diagnosed with Autism Spectrum Disorder.

**Admission Criteria**
- See Common Criteria
- The member is under the age of twenty-one;
- The member lives in a community setting;
- The member has a diagnosis of Autism Spectrum Disorder diagnosed by a practitioner whose scope of practice includes the diagnosis and treatment of ASD.
- The completed assessment identifies the need for interventions.

**Continuing Stay Criteria**
- See Common Criteria

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

- See Common Best Practices
  AND
- All assessments require a signed order from a practitioner whose scope of practice includes the diagnosis and treatment of ASD;
  AND
- Assessments include the development of a treatment plan and have a clinical focus to assess behaviors which interfere with typical development. Tools to assess skills and behavior may be utilized and include, but are not limited to:
  - The Assessment of Basic Language and Learning Skills (ABLLS);
  - The Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP); or
- Treatment plan
  - The individual who developed the treatment plan is responsible for the implementation of the treatment plan.
  - The treatment plan must include behavior analytic intervention methods proven to be effective, such as Applied Behavior Analysis (ABA), to address what was identified in the assessment.
  - At a minimum, the treatment plan includes the following:
    - Diagnosis identifying autism spectrum disorder (ASD); and
    - The signatures of the practitioner responsible for implementing the treatment plan and the signatures of the parents or guardians involved in the care of the individual receiving CIBS services.
- Interventions
  - Interventions may be provided in an individual, family or group setting.
  - Interventions must be focused on achieving the goals and addressing the needs identified in the treatment plan for the CIBS eligible individual.
  - Interventions are only be provided after an assessment has been performed and a treatment plan has been developed.
  - Additional interventions may be requested through prior authorization. The prior authorization request must include a new assessment and copy of the treatment plan that meets the above criteria.
  - Training may be provided with or without the child present.
  - Training must be child-centered and focused on training the family or guardians in developing the skills needed to address the ongoing needs of the CIBS eligible individual.
  - Training must assist the family or guardians to carry out behavior analytic interventions based on evidence-based practices, published research and designs.
  - Training must include instruction in behavior interventions to the family or guardians and other supportive caregivers.
- Practitioners
  - The following practitioners may conduct assessments, render CIBS interventions, and supervise practitioners if applicable and consistent with scope of practice, education, training, and experience:
    - A psychologist licensed by the Ohio board of psychology and practicing according to agency 4732 of the Administrative Code;
    - A licensed professional clinical counselor (LPCC), licensed independent social worker (LISW), or licensed independent marriage and family therapist (LIMFT) licensed by the Ohio counselor, social worker, and marriage and family therapist (CSWMFT) board.
    - A certified Ohio behavioral analyst (COBA) certified by the Ohio board of psychology.
    - A professional medical group consisting of providers who meet the requirements.
    - A medicaid school program operating in accordance with Ohio statutes.
  - The following practitioners may only render the interventions set forth in the treatment plan of a CIBS eligible individual as applicable within their scope of practice and consistent with their education, training, and experience:
A licensed professional counselor (LPC), licensed social worker (LSW), or marriage and family therapist licensed (MFT) by the Ohio CSWMFT board. Such practitioners must:

a. Work under the general supervision of a provider.

b. Be trained regarding the implementation of the treatment plan by the supervisor.

c. A paraprofessional who possesses at least a bachelor's degree in psychology, special education, or a related discipline. Such practitioners must:

i. Work under the direct supervision of one of the providers found in

ii. If acting on the license of and working under the direct supervision of a provider the paraprofessional must be registered with the appropriate licensing board as a trainee, assistant, or intern as applicable; or

iii. If operating under the medicaid school program, be supervised by a qualifying provider listed above.

Limitations and Exclusions

- Services not identified in the approved treatment plan.
- Experimental behavioral methods or models.
- Services including nonhuman elements, including animal therapy.
- Sex therapy, psychoanalysis, or hypnotherapy.
- Education and related services as described by the individuals with disability education act (IDEA).
- Vocational services that are otherwise available to the child through a program funded under Section 110 of the Rehabilitation Act of 1973.
- Services required as a component of adult day care programs.
- A maximum of four hours of assessments are allowed per consecutive twelve month period. This limit may be exceeded if medically necessary through prior authorization.
- A provider of CIBS, who is a family member or guardian of the CIBS eligible individual, shall not be reimbursed for services.
- Community Psychiatric Supportive Treatment (CPST) is not reimbursable when an individual is receiving CIBS interventions as part of an approved treatment plan.
- CIBS interventions are not reimbursable under Therapeutic Behavioral Services (TBS) and Psychosocial Rehabilitation (PSR).

COMMUNITY PSYCHIATRIC SUPPORT AND TREATMENT

Community psychiatric supportive treatment (CPST) service provides an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

Admission Criteria

- See Common Criteria

AND

- The Member has a DSM diagnosis which has created a reduced level of functioning and subjective distress.

AND

- Less intensive services would not be adequate to assist the member in reaching identified treatment goals.

AND

- Co-occurring mental health and substance use disorders and/or co-morbid physical conditions can be safely managed.
AND

- In collaboration with the CPST provider, the member is willing and able to connect with individual natural supports, community resources and activities that will enable community integration.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Best Practices
- Activities of the CPST service shall consist of one or more of the following:
  - Ongoing assessment of needs;
  - Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian;
  - Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian;
  - Coordination of the ISP, including:
    - Services identified in the ISP;
    - Assistance with accessing natural support systems in the community; and
    - Linkages to formal community service/systems;
  - Symptom monitoring;
  - Coordination and/or assistance in crisis management and stabilization as needed;
  - Advocacy and outreach;
  - As appropriate to the care provided to individuals, and when appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn;
  - Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment; and
  - Activities that increase the individual's capacity to positively impact his/her own environment.
  - The methods of CPST service delivery shall consist of:
    - Service delivery to the person served and/or any other individual who will assist in the person’s mental health treatment.
    - Service delivery may be face-to-face, by telephone, and/or by video conferencing; and
    - Service delivery may be to individuals or groups.

- CPST services are not site specific. However, they must be provided in locations that meet the needs of the persons served. When a person served is enrolled in a residential treatment or residential support facility setting, CPST services must be provided by staff that are organized and distinct and separate from the residential service as evidenced by staff job descriptions, time allocation or schedules, and development of service rates.
- There must be one CPST staff who is clearly responsible for case coordination. This staff person must be an employee of an agency that is certified by ODMH to provide CPST services. This person may delegate CPST services to eligible providers internal and/or external to the certified agency as long as the following requirements and/or conditions are met
  - All delegated CPST activities are consistent with this rule in its entirety;
  - The delegated CPST services may be provided by an entity not certified by ODMH to provide CPST services as long as there is written agreement between the certified agency and the non-certified entity that defines the service expectations, qualifications of staff, program and financial accountability, health and safety requirements, and required documentation; and
An entity that is not certified by ODMH for CPST service may seek reimbursement for CPST services through a certified agency and with a written agreement as required in this paragraph.

- Providers of CPST service shall have a staff development plan based upon individual needs of CPST staff. Evidence that the plan is being followed shall be maintained. The plan shall address, at a minimum, the following:
  - An understanding of systems of care, such as natural support systems, entitlements and benefits, inter- and intra-agency systems of care, crisis response systems and their purpose, and the intent and activities of CPST;
  - Characteristics of the population to be served, such as psychiatric symptoms, medications, culture, and age/gender development; and
  - Knowledge of CPST purpose, intent and activities.

- Community psychiatric support treatment (CPST) service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Administrative Code.

### CRISIS INTERVENTION

**CRISIS INTERVENTION** Crisis Intervention is a timely face to face intervention with members who are experiencing a life threatening or complex emergent situation related to mental illness or a substance use disorder.

The goals of crisis intervention are to ease the crisis, re-establish safety and institute interventions to minimize psychological trauma.

Activities may include: emergent care, assessment, immediate stabilization, de-escalation, counseling, care planning and resolution.

**Admission Criteria**

- See Common Criteria
- The member has self-identified that he/she is experiencing an acute escalation of symptoms resulting in a level of distress that cannot be managed in the member’s current situation. OR
- The member’s family members/collaterals who have knowledge of the crisis situation and the member’s typical level of functioning, present the member in need of crisis intervention. OR
- The member needs an immediate assessment of risk, mental status, substance use, and medical stability; and to determine the member’s urgent needs and whether an inpatient admission is warranted. OR
- The member requires a short-term crisis intervention, including de-escalation, crisis resolution and debriefing with the member’s treating provider.

**Continuing Stay Criteria**

- See Common Criteria
- The responsible crisis provider has completed a preliminary assessment of risk, mental status and medical stability and determined the need for further evaluation or services including referral or linkage to appropriate community services in the least restrictive level of care. OR
- With the member’s consent, the responsible crisis provider has contacted members of the family/collateral sources to gather pertinent information for the purpose of the preliminary assessment. OR
- The crisis provider requires consultation with a physician or other qualified medical, behavioral, or substance use provider to assist with the member’s current crisis.

**Discharge Criteria**

- See Common Criteria
- AND
The member’s symptoms have been reduced or restored to the previous level of functioning and/or the member can be safely and effectively treated in an ambulatory setting.

OR

After completion of the crisis evaluation, the crisis provider has determined that the member is at imminent risk of harm and requires inpatient hospitalization.

OR

After completion of the crisis evaluation, the crisis provider has determined the presence of substance use or medical problems that require another level of care.

OR

The member refuses to participate in crisis intervention services despite efforts by the crisis provider to engage the member in participation.

Clinical Best Practices

- See Common Best Practices
- Crisis Intervention will not be reimbursed when a member is enrolled in ACT, IHBT or receiving services in a SUD residential treatment facility.

DAY TREATMENT

Day Treatment is an intensive, structured, goal-oriented, distinct and identifiable group treatment service that addresses the individualized mental health needs of the client. The mental health day treatment service is clinically indicated by assessment with clear admission and discharge criteria. The environment at this level of treatment is highly structured, and has an appropriate staff-to-client ratio to guarantee sufficient therapeutic services and professional monitoring, control, and protection. The purpose and intent of mental health day treatment is to stabilize, increase or sustain the highest level of functioning.

Admission Criteria

- See Common Criteria
  AND
- The member has a Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI)
  AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction for a least 3 hours per day, 4 days per week. Examples include:
  - Assessment requires frequent interaction with the member, and observation of the member with others.
  - The treatment plan must be changed frequently, which requires that the provider have face-to-face interactions with the member several times a week.

OR

- The member requires engagement and support, which requires extended interaction between the member and the program. Examples include:
  - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.
  - The member has been unable to access or utilize the member’s family or other natural resources on his or her own.

OR

- The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
  - Maintain his or her current living situation;
  - Return to work or school

OR

- The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include the following:
  - Assistance with developing skills needed to self-manage medications;
  - Assistance with making progress towards goals in spite of an environment that does not support recovery and/or limited community support services.

- Additional Criteria for Overnight Housing Couples with a Day Treatment Program
  - Overnight housing is covered by the benefit plan.
AND
  o The treatment setting is separate from the housing.
AND
  o Either of the following apply:
    ▪ An unsupportive or high-risk living situation is undermining the member’s recovery;
    ▪ Routine attendance at Day Treatment is hindered by a lack of transportation.

  • A mental health day treatment program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities that may include, but are not limited to, the following:
    o Determination of needed mental health interventions
    o Skills development of interpersonal and social competency, problem solving, conflict resolution, and emotions/behavior management
    o Developing of positive coping mechanisms
    o Managing mental health and behavioral symptoms to enhance independent living, and
    o Psychoeducational services including instruction and training of persons served in order to increase their knowledge and understanding of their psychiatric diagnosis (es), prognosis (es), treatment, and rehabilitation in order to enhance their acceptance, increase their cooperation and collaboration with treatment and rehabilitation, and favorably affect their outcomes. Such education shall be consistent with the individual’s ITP and be provided with the knowledge and support of the interdisciplinary/intersystem team providing treatment in coordination with the ITP.

Continuing Stay Criteria
  • See Common Criteria

Discharge Criteria
  • See Common Criteria

Clinical Best Practices
  • See Common Best Practices
AND
  • The psychiatrist and treatment team completes the initial evaluation commensurate with the member’s needs, no later than 24 hours following admission.
  • During admission, a psychiatrist is available to consult with the program during and after normal business hours.
  • A psychiatrist sees the member commensurate with the member’s needs, with no less than weekly visits.
  • Service Delivery
    o When the service is provided for less than 2 ½ hours per day, the mental health day treatment hourly billing code must be used.
    o When the service is provided for 2 ½ or more hours per day, the mental health day treatment per diem must be used and the service must:
      ▪ Be delivered at a nationally-accredited program and must be provided by a licensed practitioner, or an unlicensed practitioner under the general supervision of a licensed independent practitioner on-site.
      ▪ The staff to client ratio cannot exceed 1:12

Limitations and Exclusions
  • Reimbursement for Mental Health Day Treatment will not be made while patient is enrolled in ACT or IHBT or a SUD residential treatment facility.
  • Other behavioral health services may be reimbursed on the same day as Mental Health day Treatment except for the following:
    o Mental Health and SUD group psychotherapy and group counseling
    o Group therapeutic behavioral services
    o Group community psychiatric supportive treatment
    o A per diem and hourly reimbursement will not be made on the same day with the same provider for the same individual.
A medicaid recipient can only receive one mental health day treatment service per day.

**INDIVIDUALIZED PLACEMENT AND SUPPORT/SUPPORTED EMPLOYMENT**

The purpose and intent of Individualized Placement and Support Supported Employment (IPS-SE) is to promote recovery through the implementation of evidence based and best practices which allow individuals with severe and persistent mental illness or co-occurring mental illness and a substance use disorder to obtain and maintain integrated competitive meaningful employment by providing training, ongoing individualized support, and skill development that honor client choice.

Recovery management is the coordination of all specialized recovery services program services received by an individual and assisting him or her in gaining access to needed Medicaid services, as well as medical, social, educational, and other resources, regardless of funding source. The Recovery Manager is the person responsible for performing the needs-based assessment and monitoring the provision of services included in the person-centered care plan to ensure the individual's needs, preferences, health and welfare are supported.

**Admission Criteria**

- See Common Criteria
- The member is 21 years of age or older, has a current diagnosis of Schizophrenia, Bipolar, Major Depressive Disorder or Severe Affective Disorder, and is enrolled in the 1915(i) Waiver.
- The member has chosen to participate in activities to support the process of acquiring and maintaining employment.
- The member will participate in an initial assessment using the "Adult Needs and Strengths Assessment (ANSA)" and obtain a qualifying score of either:
  - Two or greater on at least one item in the "mental health needs" or "risk behaviors" sections; or
  - Three on at least one item in the "life domain functioning" section.
- The member demonstrates needs related to the management of his or her behavioral health as documented in the "ANSA".
- The member has at least one of the following risk factors prior to enrollment in the program:
  - One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or
  - A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment while residing in that correctional facility; or
  - Two or more emergency department visits with a psychiatric diagnosis; or
  - A history of treatment in an intensive outpatient rehabilitation program for greater than ninety days.
- The member meets at least one of the following:
  - Currently have a need for one or more of the specialized recovery services to maintain stability, improve functioning, prevent relapse, maintain residency in the community, and be assessed and found that, if not for the provision of home and community-based services (HCBS) for stabilization and maintenance purposes, he or she would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning); or
  - Reside in an HCBS setting;
  - Demonstrate a need for specialized recovery services, and not otherwise receive those services;
  - Have needs that can be safely met through the program in an HCBS setting; and
  - Participate in the development of a person-centered care plan.
- At least one of the following Supported Employment services and activities is provided to the member:
Vocational Assessment
Development of a Vocational Plan
On-the-job Training and skill development
Job seeking skills training (JSST)
Job development and placement
Job coaching
Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports
Benefits planning
General consultation, advocacy, building and maintaining relationships with employers
Rehabilitation guidance and counseling
Time unlimited vocational support.

Continuing Stay Criteria
- See Common Criteria
  AND
- The member agrees to receive services according to his/her person-centered care plan and consent by signing and dating the plan; and
  AND
- Ongoing and at least annual reassessments will occur according to the care plan.

Discharge Criteria
- See Common Criteria
  AND
- Goals of the person-centered plan related to employment have been substantially met.
  OR
- The member requests a discharge from this service.
  OR
- The member does not currently desire competitive employment.
  AND
- The duration of services is for up to one year, but a six month review with person-centered plan to review progress is recommended. The recovery manager can recommend extended follow along after twelve months.

Clinical Best Practices
- See Common Best Practices
  AND
- The responsible service provider in conjunction with the treatment team and, whenever possible, the member develops a person-centered service plan that includes a description of the following:
  - The member’s recovery and resiliency goals;
  - Strengths;
  - Problems;
    - Specific and measurable goals for each problem;
    - Interventions that will support the member in meeting the goals.
- The services plan must reflect the services and supports that are important for the member to meet the needs identified through the assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
- The provider also completes a comprehensive employment assessment in order to establish a vocational profile and individual employment support plan.
- The person-centered service plan and employment plan are updated or revised at least quarterly, or as necessary to document changes in the member's service needs.
- Discharge Planning
  - Prevocational services are designed to be provided for a limited time in order to prepare a member for employment. If a member has been receiving prevocational services for more than one year and is not ready for regular employment, the
interdisciplinary team should re-evaluate the necessity of prevocational services and explore other service options to meet the member’s vocational needs, if necessary.

- **Supported Employment Service Delivery**
  - There are eight core principles to the IPS model:
    - Zero Exclusion
    - Integrated Employment & Treatment
    - Competitive Jobs
    - Rapid Job-Search
    - Systematic Job Development
    - Time-Unlimited Support
    - Consumer Preferences
    - Benefits Planning
  - The following are requirement components of the program:
    - a. Vocational Assessment
    - b. Development of a Vocational Plan;
    - c. On-the-job Training and skill development;
    - d. Job seeking skills training (JSST);
    - e. Job development and placement;
    - f. Job coaching;
    - g. Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports;
    - h. Benefits planning;
    - i. General consultation, advocacy, building and maintaining relationships with employers;
    - j. Rehabilitation guidance and counseling; or,
    - k. Time unlimited vocational support.
  - Supported Employment can be provided in conjunction with any of the following services:
    - Facilitation of natural supports;
    - Transportation; or,
    - Peer services.
  - The outcome of an employment service is that individuals will obtain and maintain a job of their choosing through rapid job placement which will increase their self-sufficiency and further their recovery. Employment services should be coordinated with mental health services and substance use treatment and services.

### Limitations and Exclusions
- Supervisory activities rendered as a normal part of the business setting.
- Supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business.
- Transportation to and from the work site will be a component of - and the cost of this transportation will be included in - the rate paid to providers, unless the individual can access public transportation or has other means of transportation available to them. If public transportation is available, then it should be utilized by the individual, if at all possible.
- Employment services may be used for an individual to gain work-related experience considered crucial for job placement (e.g., unpaid internship), only if such experience is vital to the person to achieve his or her vocational goal.
- Services may not be provided on the same day and at the same time as services that contain elements integral to the delivery of employment services (e.g., rehabilitation).
- Services do not include adaptations, assistance, and training used to meet an employer’s responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.
INPATIENT & INSTITUTIONS FOR MENTAL DISEASE

ACUTE INPATIENT Inpatient is a structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

The course of treatment in an inpatient setting is focused on addressing the factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

INSTITUTIONS FOR MENTAL DISEASE An IMD is a hospital, nursing facility, or other institution of more than sixteen beds which primarily provides diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services intended to provide members with improved access to timely, medically appropriate, and cost-effective services by allowing IMDs to be utilized in lieu of otherwise covered settings, such as inpatient psychiatric units in general medical hospitals.

Admission Criteria

- See Common Criteria
- The member’s condition and/or the member’s history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include the following:
  - A life-threatening suicide attempt;
  - Self-mutilation, injury, or violence towards others or property;
  - Threats of serious harm to self or others;
  - Command hallucinations directly harm to self or others.
- The member’s condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:
  - A physical cause for the member’s signs and symptoms cannot be ruled out in a less intensive setting.
  - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.
- The factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to changes in the member’s signs and symptoms, and/or psychosocial and environmental factors. Examples include:
  - Impairment of behavior or condition that interferes with activities of daily living (ADLs) to the extent that the welfare of the member or others is endangered.
  - Psychosocial and environmental problems that threaten the member’s safety or undermines engagement in a less intensive level of care.
- The factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.
- For IMD settings, the member must be 21 to 64 years old.

Continuing Stay Criteria

- See Common Criteria
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
  - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating);
  - Health-related services provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services
are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

AND

- For IMD settings, there is a limit of 15 days per month.

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Best Practices

AND

- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation within 24 hours of admission.

- During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.

- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

INTENSIVE HOME-BASED TREATMENT SERVICES

Intensive home based treatment (IHBT) service is a comprehensive mental health service provided to a child/adolescent and his or her family that integrates community psychiatric supportive treatment (CPST) service or health home service for persons with serious and persistent mental illness for a person enrolled in the service, mental health assessment service, mental health crisis response, behavioral health counseling and therapy service, and social services with the goal of either preventing the out-of-home placement or facilitating a successful transition back to home. IHBT service may also be provided to transitional age youth between the ages of eighteen and twenty-one who have an onset of serious emotional and mental disorders in childhood or adolescence. These intensive, time-limited mental health services are provided in the child/adolescent's natural environment with the purpose of stabilizing and improving his/her mental health functioning.

The purpose of IHBT is to enable a child/adolescent with serious emotional disturbance (SED) to function successfully in the least restrictive, most normative environment. IHBT services are culturally, ethnically, racially, developmentally and linguistically appropriate, and respect and build on the strengths of the child/adolescent and family's race, culture, and ethnicity.

Admission Criteria

- See Common Criteria

AND

- The member is clinically determined to meet the "person with serious emotional disturbance" (SED) criteria

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2 Per paragraph (B) (48) of rule 5122-24-01 of the Administrative Code: "Person with serious emotional disturbance" means a person less than eighteen years of age who meets criteria that is a combination of duration of impairment, intensity of impairment and diagnosis. (i) Under eighteen years of age; (ii) Marked to severe emotional/behavioral impairment; (iii) Impairment that seriously disrupts family or interpersonal relationships; and (iv) May require the services of other youth-serving systems (e.g., education, human services, juvenile court, health, mental health/mental retardation, youth services, and others). (b) Marked-to-severe behavioral impairment is defined as impairment that is at or greater than the level implied by any of the following criteria in most social areas of functioning: (i) Inability or unwillingness to cooperate or participate in self-care activities; (ii) Suicidal preoccupation or rumination with or without lethal intent; (iii) School refusal and other anxieties or more severe withdrawal and isolation; (iv) Obsessive rituals, frequent anxiety attacks, or major conversion symptoms; (v) Frequent episodes of aggressive or other antisocial behavior, either mild with some preservation in social relationships or more severe requiring considerable constant supervision; and (vi) Impairment so severe as to
OR

- IHBT may also be provided to an individual age eighteen through twenty-one who meets all of the other diagnostic criteria for SED, and is still living at home and/or in the custody of a public child serving agency and/or under the jurisdiction of juvenile court and/or in the custody of the Ohio department of youth services.

AND

- Meets one or more of the following criteria:
  - Is at risk for out-of-home placement due to his/her behavioral health/mental health condition;
  - Has returned within the previous thirty days from an out-of-home placement or is transitioning back to their home within thirty days; or
  - Requires a high intensity of mental health interventions to safely remain in or return home.

AND

- The youth must score the following on the life functioning domain, child behavioral/emotional needs, and child risk behaviors dimensions of the child and adolescent needs and strengths (CANS) assessment tool available at www.medicaid.ohio.gov:
  - A rating of "three" on one item or a rating of "two" on two of the following life functioning domain items:
    - Family;
    - Legal;
    - Social functioning;
    - Living situation;
    - School behavior; or
    - School attendance.
  - A rating of "two" or higher on one or more items within the child behavioral/emotional needs criteria:
    - Psychosis;
    - Impulse/Hyperactivity;
    - Depression;
    - Anxiety;
    - Oppositional;
    - Conduct;
    - Adjustment to trauma;
    - Anger control; or
    - Substance use.
  - A rating of "two" or higher on one or more items within the child risk behaviors criteria:
    - Suicide risk;
    - Self-mutilation;
    - Other self-harm;
    - Danger to others;
    - Sexual aggression;
    - Runaway;
    - Delinquency;
    - Judgment;
    - Fire setting; or
    - Social behavior.

AND

preclude observation of social functioning or assessment of symptoms related to anxiety (e.g., severe depression or psychosis). (c) An impairment that seriously disrupts family or interpersonal relationships is defined as one: (i) Requiring assistance or intervention by police, courts, educational system, mental health system, social service, human services, and/or children's services; (ii) Preventing participation in age-appropriate activities; (iii) In which community (home, school, peers) is unable to tolerate behavior; or (iv) In which behavior is life-threatening (e.g., suicidal, homicidal, or otherwise potentially able to cause serious injury to self or others).
• The youth must have at least one family member or other individual who is a part of the youth's home who authorizes IHBT services to be provided, and actively participates in the provision of IHBT.

Continuing Stay Criteria

• See Common Criteria
• AND
• The service is time-limited, with length of stay matched to the presenting mental health needs of the child/adolescent. The maximum amount of IHBT service which may be prior authorized at any one time is 72 hours.
  • IHBT should not exceed six months length of stay. A continued stay review must be documented for each child/adolescent receiving IHBT beyond six months, and every forty-five days thereafter.

Discharge Criteria

• See Common Criteria

Clinical Best Practices

• See Common Best Practices
• AND
• The treatment plan shall be individualized based on the recipient's needs, strengths, and preferences and shall set measurable long-term and short-term goals and specify approaches and interventions necessary for the recipient to achieve the individual goals. The treatment plan shall also identify who will carry out the approaches and interventions.
• The treatment plan shall address, at a minimum, the following key areas:
  • Psychiatric illness or symptom reduction.
  • Stable, safe, and affordable housing.
  • Activities of daily living.
  • Daily structure and activities, including employment if appropriate.
  • Family and social relationships.
  • The treatment plan shall be reviewed and revised by a member of the IHBT team with the recipient whenever there is a major decision point in the recipient's course of treatment or, at a minimum, every six months.
  • In conjunction with a treatment plan review, the IHBT team member shall prepare a summary of the recipient's progress, goal attainment, effectiveness of the intervention and a recipient's satisfaction with the IHBT team interventions since enactment of the previous treatment plan.
  • The treatment plan, and all subsequent revisions of it, shall be reviewed and signed or verbally agreed upon by the recipient, the IHBT team reviewer, and the IHBT team leader.
• The following describes the activities and components of IHBT:
  • IHBT is an intensive service that consists of multiple face-to-face contacts per week with the child/adolescent and family, which includes collateral contacts related to the mental health needs of the child/adolescent as documented in the ICR. The frequency of contacts may fluctuate based on the assessed needs and unique circumstances of the child, adolescent, and family.
  • IHBT is strength-based and family-driven, with both the child/adolescent and family regarded as equal partners with the IHBT staff in all aspects of developing the service plan and service delivery;
  • IHBT is provided in the home, school, and community where the child/adolescent lives and functions;
  • Crisis response is available twenty-four hours a day, seven days a week. Crisis response may be provided through written agreement with another agency, as long as at least one agency IHBT staff is accessible to the provider agency, and is available to the client and family as needed;
Each child/adolescent and family receiving IHBT is assessed for risk and safety issues. When clinically indicated, a jointly written safety plan shall be developed that is provided to the child/adolescent and family;

Collaboration occurs with other child-serving agencies or systems, e.g., school, court, developmental disabilities, job and family services, and health care providers that are providing services to the child/adolescent and family, as well as family and community supports identified by the child/adolescent and family;

The service is flexible and individually tailored to meet the needs of the child/adolescent and family. Appointments are made at a time that is convenient to the child/adolescent and family, including evenings and weekends if necessary; Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment.

**Limitations and Exclusions**

- Time spent doing, attending, or participating in recreational activities.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family.
- Any art, movement, dance, or drama therapies.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Assessments, screenings, and diagnostic evaluations.
- Mental health day treatment.
- Individual, group, or family psychotherapy and counseling.
- Therapeutic behavioral services.
- Community psychiatric supportive treatment.
- Psychosocial rehabilitation.
- Substance use disorder residential treatment services.
- Assertive community treatment.
- Crisis intervention
- SUD case management requires prior authorization from the ODM designated entity while a recipient is enrolled in IHBT.

**OUTPATIENT SERVICES**

OUTPATIENT SERVICES: Assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting, via a secure two-way real time interactive telemental health system, or in the member’s home. The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. 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 information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices. Individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes.

The following are not considered telemental health because they don’t utilize a secure two-way real time interactive telemental health system:

- Phone-based services including phone counseling, email, texting, voicemail, or facsimile except when allowed by State regulation;
- Remote medical monitoring devices;
- Virtual reality devices;
- Internet-based services including internet-based phone calls.

Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting 60 minutes or longer. Extended outpatient sessions may require prior authorization before services are received, except in extenuating circumstances, such as a crisis.
Home-based assessment and treatment are separate services, and the findings of a home-based assessment may or may not support the need for home-based treatment.

**Admission Criteria**

- See Common Criteria AND
- Coverage for extended outpatient sessions lasting longer than 60 minutes may be indicated in the following non-routine circumstances:
  - The member is experiencing a crisis but is not at imminent risk of harm to self or others, and an extended outpatient session is appropriate for providing rapid and time-limited assessment and stabilization.
    - Consider extending coverage for crisis situations in 30-minute increments when clinically indicated.
    - Prior authorization is not required when there is a crisis.
  - An individual psychotherapy session with evaluation and management is being provided, and there is an unexpected complication resulting from pharmacotherapy, or a worsening of the member’s condition that would likely require a more intensive level of care if the outpatient session is not extended.
  - Periodic involvement of children, adolescent, or geriatric members’ family in a psychotherapy sessions when such involvement is essential to the member’s progress (e.g., when psychoeducation or parent management skills are provided).
    - This is not synonymous with marital or family therapy.
  - An extended session is otherwise needed to address new symptoms of the reemergence of old symptoms with a rapid, time-limited assessment and stabilization response. Without an extended outpatient session, the new-re-emerging symptoms are likely to worsen and require a more intensive level of care.

Extended outpatient sessions may be covered in the following circumstances, as indicated by the member’s condition and specific treatment needs:

- The member has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder, Obsessive Compulsive Disorder, or Specific Phobia, and is being treated with Prolonged Exposure Therapy.
- The member is being treated with Eye Movement Desensitization and Reprocessing (EMDR) or Traumatic Incident Reduction (TIR) for Posttraumatic Stress Disorder (PTSD).
- Borderline Personality Disorder is a covered condition, and the member is being treated with Dialectical Behavior Therapy (DBT).

Home-based outpatient assessment/or treatment may be covered when the member is homebound. A member is homebound when:

- A physical condition restricts the member’s ability to leave his/her residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
- A behavioral health condition is manifested in part by an inability to leave home, or is such that it would not be considered safe for the member to leave home unattended.

Home-based outpatient assessment may be covered when:

- An assessment of the changes in the member’s signs and symptoms, and/or psychosocial and environmental factors is required to determine if behavioral health services are needed.
- An assessment of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.

Home-based outpatient treatment may be covered when:

- The member’s signs and symptoms are primarily or exclusively experienced at home.
- The member’s condition undermines participation in treatment at an ambulatory setting.

Coverage for outpatient telemental health service may be covered when:

- The Outpatient Admission Criteria are met.
A secure two-way real-time interactive telemental health system is available to facilitate interaction between the member and the provider.

Continuing Stay Criteria
- See Common Criteria

Discharge Criteria
- See Common Criteria

Clinical Best Practices
- See Common Best Practices
- The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member's recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member's functional status improves, the frequency of visits decreases to meet the member's current needs and treatment goals. Factors that may impact frequency and duration include the following:
  o The goals of treatment;
  o The member’s preferences;
  o Evidence from clinical best practices which supports frequency and duration;
  o The need to monitor and manage imminent risk of harm to self, others, and/or property.
- The provider informs the member of the process to be followed in the event of an after-hours emergency, such as the availability of on-call services. The process is not solely reliant on the Emergency Room.
- The patient's file must substantiate the medical necessity of services performed, and each record is expected to bear the signature and indicate the discipline of the professional who entered it. The following items must be included as documentation if applicable at a minimum:
  o A description of the patient's symptoms and functional impairment;
  o All relevant diagnoses pertaining to medical or physical conditions as well as to behavioral health;
  o Evidence that the patient has sufficient cognitive capacity to benefit from treatment;
  o A treatment plan that specifies treatment goals, tracks responses to ongoing treatment, and presents a prognosis;
  o The type, duration, and frequency of treatment, with dates of service;
  o Medications taken by or prescribed for the patient;
  o The amount of time spent by the provider face-to-face with the patient;
  o Test results, if applicable, with interpretation;
  o Summaries of psychotherapy sessions; and
  o All psychotherapy notes.

Additional best practices for home-based assessment and treatment are:
- The following conditions may support home-based assessment and/or treatment:
  o Agoraphobia or Panic Disorder;
  o Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairments of thoughts/cognition grossly affect the member’s judgment and decision making, and therefore the member’s safety;
  o Depression with severe vegetative symptoms;
  o Behavioral health problems associated with medical problems that render the member homebound.

Additional best practices for telemental health are:
- Asynchronous store and forward technologies (i.e., the transmission of a member's clinical record, lab results, or other clinical information from an originating site to the provider at a distant site) is not part of the standard of care for telemental health.
- The following are not considered telemental health because they don’t utilize a secure two-way real-time interactive telemental health system:
- Phone-based services including phone counseling, email, texting, voicemail, or facsimile except when allowed by State regulation;
- Remote monitoring devices;
- Virtual reality devices;
- Internet-based services including internet-based phone calls.

- A qualified provider at the distant site is licensed in the state where the member resides.
- Delivery of group or family psychotherapy to members at different locations (i.e., multipoint videoconferencing) may be covered when all members are in the state where the provider is licensed, and all locations provide secure two-way real time interactive telemental health systems.
- Services are delivered in a manner consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security regulations and standards.

AND

- The patient's file must substantiate the medical necessity of services performed, and each record is expected to bear the signature and indicate the discipline of the professional who entered it. The following items must be included as documentation if applicable at a minimum:
  - A description of the patient's symptoms and functional impairment;
  - All relevant diagnoses pertaining to medical or physical conditions as well as to behavioral health;
  - Evidence that the patient has sufficient cognitive capacity to benefit from treatment;
  - A treatment plan that specifies treatment goals, tracks responses to ongoing treatment, and presents a prognosis;
  - The type, duration, and frequency of treatment, with dates of service;
  - Medications taken by or prescribed for the patient;
  - The amount of time spent by the provider face-to-face with the patient;
  - Test results, if applicable, with interpretation;
  - Summaries of psychotherapy sessions; and
  - All psychotherapy notes.

Limitations and Exclusions

- Services provided by unlicensed individual other than a supervised trainee;
- Services that are provided in facilities regulated by the state board of education;
- Activities, testing, or diagnosis conducted for purposes specifically related to education;
- Services that are unrelated to the treatment of a specific mental behavioral health complaint but serve primarily to enhance skills or to provide general information, examples of which are given in the following non-exhaustive list:
  - Encounter groups, workshops, marathon sessions, or retreats;
  - Sensitivity training;
  - Sexual competency training;
  - Recreational therapy (e.g., art, play, dance, music);
  - Services intended primarily for social interaction, diversion, or sensory stimulation; and
  - The teaching or monitoring of activities of daily living (such as grooming and personal hygiene);
  - Psychotherapy services if the patient cannot establish a relationship with the provider because of a cognitive deficit;
  - Family therapy for the purpose of training family members or caregivers in the management of the patient; and
  - Self-administered or self-scored tests of cognitive function.

### PEER RECOVERY AND SUPPORT

PEER RECOVERY AND SUPPORT: The Peer Recovery Support (PRS) service provides community-based supports to individuals with or in recovery from a mental illness and/or substance use disorders with individualized and recovery focused activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports a person’s ability to promote his or her own recovery. Peer recovery supporters use their own experiences with mental illness, to help individuals reach their recovery goals.
PRS services promote self-directed recovery by assisting an individual in:

- Ongoing exploration of recovery needs
- Achieving personal independence as identified by the individual
- Encouraging hope
- Facilitating further development of daily living skills
- Developing and working toward achievement of personal recovery goals
- Modeling personal responsibility for recovery
- Teaching skills to effectively navigate to the health care delivery system to effectively and efficiently utilize services
- Providing group facilitation that addresses symptoms, behaviors, though processes, etc., that assist an individual in eliminating barriers to seeking or maintaining recovery, employment, education, or housing
- Assisting with accessing and developing natural support systems in the community
- Promoting coordination and linkage among similar providers
- Coordinating and/or assistance in crisis interventions and stabilization as needed
- Conducting outreach
- Attending and participating in treatment teams
- Assisting individuals in the development of empowerment skills through self-advocacy and stigma busting activities that encourage hope

Peer recovery services are not site specific but shall be provided in locations that meet the needs of the individual.

Recovery management is the coordination of all specialized recovery services program services received by an individual and assisting him or her in gaining access to needed Medicaid services, as well as medical, social, educational, and other resources, regardless of funding source. The Recovery Manager is the person responsible for performing the needs-based assessment and monitoring the provision of services included in the person-centered care plan to ensure the individual's needs, preferences, health and welfare are supported.

**Admission Criteria**

- See Common Criteria
  AND
- The member has a Serious Mental Illness (SMI) or a Substance-Related Disorder
  AND
- The member's condition indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:
  - The member requires information about their behavioral health condition, evidence-based treatment, approaches to self-care, or community resources;
  - The member could benefit from learning skills related to problem-solving, communication, managing crises or stress, activating and engaging in self-care, or promoting recovery;
  - The member requires assistance navigating the system of care.
  AND
- The member is receiving behavioral health services, or is likely to engage in treatment with the provision of Peer Services and Supports.
  AND
- The member is 21 years of age or older, has a current diagnosis of Schizophrenia, Bipolar, Major Depressive Disorder or Severe Affective Disorder, and is enrolled in the 1915(i) Waiver.
  AND
- The member will participate in an initial assessment using the "Adult Needs and Strengths Assessment (ANSA)" and obtain a qualifying score of either:
  - Two or greater on at least one item in the "mental health needs" or "risk behaviors" sections; or
  - Three on at least one item in the "life domain functioning" section.
  AND
- The member demonstrates needs related to the management of his or her behavioral health as documented in the "ANSA";
The member has at least one of the following risk factors prior to enrollment in the program:
- One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or
- A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment while residing in that correctional facility; or
- Two or more emergency department visits with a psychiatric diagnosis; or
- A history of treatment in an intensive outpatient rehabilitation program for greater than ninety days.

The member meets at least one of the following:
- Currently have a need for one or more of the specialized recovery services to maintain stability, improve functioning, prevent relapse, maintain residency in the community, and be assessed and found that, if not for the provision of home and community-based services (HCBS) for stabilization and maintenance purposes, he or she would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning); or
- Reside in an HCBS setting;
- Demonstrate a need for specialized recovery services, and not otherwise receive those services;
- Have needs that can be safely met through the program in an HCBS setting; and
- Participate in the development of a person-centered care plan.

Continuing Stay Criteria
- See Common Criteria

The member agrees to receive services according to his/her person-centered care plan and consent by signing and dating the plan; and

Ongoing and at least annual reassessments will occur according to the care plan.

Discharge Criteria
- See Common Criteria

The frequency and duration of PRS will be identified on the Person-Centered Plan and must be supported by an identified need and recovery goal. PRS will not substitute or supplant natural supports.

The frequency and duration of peer recovery support encounters is anticipated to decline as the individual progresses in his or her recovery, builds natural supports and strengths, and is better able to navigate recovery in his or her community of choice.

Clinical Best Practices
- See Common Best Practices

The Peer completes an evaluation of the family’s needs upon referral.
- For members who are transitioning from inpatient or residential treatment, the Peer contacts the member’s family prior to discharge or within 24 hours of referral.
- As part of the evaluation, the Peer provides the member with information about Peer Services and Supports, and verifies that the member wants these services.
- In the event that the member declines services, the Peer provides information about obtaining services should the family’s needs change.

The Peer, in conjunction with the member’s family, develops a service plan that addresses the following:
- The member’s recovery and resiliency goals;
- The member’s strengths;
- The member’s educational needs;
- The member’s self-care and activation strategies;
• Problems;
• Specific and measurable goals for each problem;
• Interventions that will support the member in meeting the goals.

The service plan may be informed by the findings of the member’s clinical evaluation.

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<th>PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING</th>
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**PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING** includes the administration, interpretation, and scoring of the tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

**Psychological Test Evaluation Services** is a set of formal procedures utilizing reliable and validated tests designed to measure areas of intellectual, cognitive emotional, and behavioral functioning, in addition to identifying psychopathology, personality style, interpersonal processes, and adaptive skills. Service activities can include test selection, review of records, consultation with referral source, integration of clinical data, clinical decision making, preparation of the testing report, and reviewing the results of testing with member and/or caregivers.

**Admission Criteria**

- See Common Criteria

AND

- Services are medically necessary defined as:
  - Consistent with generally accepted standards of clinical practice;
  - Consistent with services backed by credible research soundly demonstrating that the service(s) will have a measurable and beneficial health outcome, and are therefore not considered experimental;
  - Consistent with Optum’s best practice guidelines;
  - Clinically appropriate for the member’s behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

- Prior to testing, a clinical evaluation of the member is completed by a behavioral health or medical professional who is the referring provider or the psychologist conducting the psychological assessment.
  - The member’s condition cannot be conclusively assessed with a standard clinical evaluation due to the nature of the member’s signs and symptoms and/or psychological and environmental factors (i.e., the factors leading to the request for testing). Examples include:
    - A differential diagnosis between more than one behavioral health condition or between a behavioral health and a medical condition cannot be made.
    - The member presents with atypical symptoms.

**Clinical Best Practices**

- See Common Best Practices

AND

- The clinical evaluation completed prior to testing:
  - Identifies specific, outstanding clinical questions that must be answered by testing in order to establish the member’s diagnosis or inform the treatment plan.
  - Verifies that outstanding clinical questions cannot be answered by the clinical evaluation.
  - Informs the test battery.

- The tests in the battery and the number of hours requested are appropriate to answer specific clinical questions that could not be answered by the clinical evaluation.
  - The total number of units of service time includes the total time necessary to complete face-to-face administration, scoring, interpretation, and report writing up to 150% of the standard administration time recommended by the test publisher, plus service time for testing feedback. Interpretive feedback session should not require more than one hour service time in most cases. Additional units for an extended feedback session should be supported by the clinical circumstances. A request in excess of 150% of the standard administration time plus feedback is supported by extenuating circumstances.
with evidence submitted by the provider. Examples of extenuating circumstances include the following:

- The member has significant functional impairment. Examples include but are not limited to: sensory deficits and/or physical disabilities which necessitate modification in standard administration procedures; severe oppositional behavior; attentional deficits or developmental disabilities which require the examiner to provide frequent re-direction and/or breaks for the member during testing. Note: testing should not be conducted if extenuating circumstances such as these are so severe that it could reasonably pose a threat to the reliability or validity of test results.
- The member has an intellectual disability.
  - At least one unit of evaluation time and at least one unit of administration time i.e., 1 unit 96130 or 96132 plus 1 unit 96136 or 96138 is required for Psychological or Neuropsychological Testing
  - At least two (2) validated tests are required for psychological or neuropsychological testing. Administration of two or more subtests from the same instrument does not meet this requirement.
  - Maximum of one (1) automated instrument with automated scoring and interpretation is allowed for Automated Testing.
  - Both Test Evaluation codes and Test Administration and Scoring codes must be requested together for psychological or neuropsychological testing
  - The number of units Test Administration and Scoring should be consistent with the proposed tests to be administered for the battery. Requests for Test Evaluation Services that significantly exceed Test Administration and Scoring services must be supported by the clinical circumstances and documented.
  - Test Evaluation codes and Test Administration and Scoring codes may not be combined with Automated Testing.
  - Psychological Test Evaluation Services (96130/96131) or Neuropsychological Test Evaluation Services (96132/96133) must be selected. A "first hour" of Test Evaluation Services cannot be billed twice using both the 96130 and 96132 codes for the same episode of testing.
- The member has abstained from using alcohol or drugs for at least six (6) weeks prior to testing, or however long is required for results to be usefully interpretable.
- Tests are administered in a variety of methods including face-to-face formats, including paper-and-pencil, computer, and visual aids.
- The provider monitors administration to ensure that the member is giving sufficient effort and attention to completing the test battery so as to ensure a valid and reliable measure is obtained.
- There is a rationale for re-testing if testing was completed within the last six (6) months, such as re-testing needed to measure changes in functional impairment or disease progression (e.g., acute head injury, stroke, speech, motor or sensory dysfunction).
- The medical record must document according to requirements in rules 5122-27-02 through 5160-22-05 of the Ohio Administrative Code.

Limitations and Exclusions

- For psychological testing or neuropsychological testing, a maximum of eight twelve hours, per recipient, per calendar year per benefit year; and
- For neuropsychological testing, a maximum of eight hours per recipient, per calendar year

**PSYCHOLOGICAL TESTING**

*Psychological Test Evaluation Services* is a set of formal procedures utilizing reliable and validated tests designed to measure areas of intellectual, cognitive emotional, and behavioral functioning, in addition to identifying psychopathology, personality style, interpersonal processes, and adaptive skills. Service activities can include test selection, review of records, consultation with referral source, integration of clinical data, clinical decision making, preparation of the testing report, and reviewing the results of testing with member and/or caregivers.
Admission Criteria and Clinical Best Practices

- The provider’s professional training and licensure include any of the following:
  - A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
  - A masters-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.
    - The masters-degreed provider has professional expertise in the types of tests/assessments being administered.
    - The masters-degreed provider is conducting test administration, scoring and interpretation in accordance with licensing standards and psychological testing professional and ethical standards.

Test Administration and Scoring is the formal process of administering reliable and validated tests selected by the doctoral-level psychologist or qualified masters-degreed provider according to standardized test manual instructions and scoring the respondents answers to test items.

Admission Criteria and Clinical Best Practices

- The provider’s professional training and licensure include any of the following:
  - A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed doctoral-level psychologist, and whose services are billed by the supervising psychologist.
    - The supervising psychologist must have face-to-face contact with the member at intake and during the feedback session.
  - The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval. A masters-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.
    - The masters-degreed provider has professional expertise in the types of tests/assessments being administered.
  - The masters-degreed provider is conducting test administration, scoring and interpretation in accordance with licensing standards and psychological testing professional and ethical standards. Psychological testing related to the treatment of chronic pain may be conducted when:
    - There is a need to further assess mood and personality characteristics which may influence the member’s experience or perception of the basis or tolerance of pain, as well as the member’s ability to cope with his/her pain; OR
    - When the member shows changes in cognitive or intellectual functioning after the long-term use of alcohol, street or prescription drugs, or upon the discontinuation of, or non-response to pain-relieving or psychotropic medications.
  - Psychological testing as a component of pre-surgical evaluation may be conducted to rule out behavioral health conditions that could contraindicate surgery, to determine the member’s ability to understand the related risks and benefits or surgery, and/or to evaluate the member’s ability to participate responsibly in post-surgical recovery behaviors and lifestyle changes.

NEUROLOGICAL TESTING

Neuropsychological Test Evaluation Services is a set of formal procedures utilizing reliable and valid tests specifically focused on identifying the presence of brain damage, injury, or dysfunction, and any associated functional deficits.

Admission Criteria and Clinical Best Practices

- Neuropsychological testing is within the scope of the provider’s professional training and licensure when the provider is any of the following:
A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.

A credentialed psychiatrist who meets the following requirements:
- Recognized certification in neurology through the American Board of Psychiatry and Neurology;
- Accreditation in behavioral neurology and neuropsychiatry through the American Neuropsychiatric Association;
- State medical licensure specifically allowing for the provision of neuropsychological testing service(s);
- Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
- Physician and supervised psychometrician(s) adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

**Test Administration and Scoring** is the formal process of administering reliable and validated tests selected by the doctoral-level psychologist or qualified masters-degreed provider according to standardized test manual instructions and scoring the respondents answers to test items.

**Admission Criteria and Clinical Best Practices**
- Neuropsychological Test Administration and Scoring is within the scope of the provider’s professional training and licensure when the provider is any of the following:
  - A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
  - A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed doctoral-level psychologist, and whose services are billed by the supervising psychologist.
    - The supervising psychologist must have face-to-face contact with the member at intake and during the feedback session.
    - The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.
  - A credentialed psychiatrist who meets the following requirements:
    - Recognized certification in neurology through the American Board of Psychiatry and Neurology;
    - Accreditation in behavioral neurology and neuropsychiatry through the American Neuropsychiatric Association;
    - State medical licensure specifically allowing for the provision of neuropsychological testing service(s);
    - Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
    - Physician and supervised psychometrician(s) adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

- Medical application of Neuropsychological testing may be covered under the medical benefit for members with the following conditions when the result of testing will influence clinical decision making (for more information, see [www.unitedhealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Neuropsychological Testing Under the Medical Benefit](https://www.unitedhealthcareonline.com/Tools-Resources/Policies-Protocols-and-Guides/Medical-Drug-Policies-Coverage-Determination-Guidelines-Commercial/Neuropsychological-Testing-Under-Medical-Benefit)):
  - Attention-deficit/hyperactivity disorder (ADHD) when all of the following are present:
    - Specific neurocognitive behavioral deficits related to ADHD need to be evaluated
    - Testing has been recommended by a physician and is related or secondary to a known or suspected organic-medical condition resulting from brain injury or disease process (e.g., concussion, intractable seizure disorder, cancer treatment effects, genetic disorders, inborn errors of metabolism)
The scope of these criteria is applicable only to neuropsychological testing that is covered by the medical benefit. These criteria do not apply to evaluate or determine educational interventions.

- Confirmed space-occupying brain lesion including but not limited to the following:
  - Brain abscess;
  - Brain tumors;
  - Arteriovenous malformations within the brain.

- Dementia or symptoms of dementia such as memory impairment or memory loss (including extrapyramidal disorders such as Parkinson's disease) that is associated with a new onset or progressive memory loss and a decline in at least one of the following cognitive domains (DSM-5):
  - Complex attention;
  - Executive function;
  - Learning and memory;
  - Language;
  - Perceptual-motor;
  - Social cognition.

- Demyelinating disorders, including multiple sclerosis

- Intellectual disability or intellectual developmental disorder, when all of the following are present:
  - The intellectual disability or intellectual developmental disorder is associated with a known or suspected medical cause (e.g., traumatic brain injury, in utero toxin exposure, early seizure disorder, sickle cell disease, genetic disorders) AND
  - The intellectual disability or intellectual developmental disorder meets all of the following criteria (DSM-5):
    - Deficits in intellectual function, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing; AND
    - Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living across multiple environments, such as home, school, work and community; AND
    - Onset of intellectual and adaptive deficits during the developmental period

The scope of these criteria is applicable only to neuropsychological testing that is covered by the medical benefit. These criteria do not apply to evaluate or determine educational interventions.

- Encephalopathy including acquired immunodeficiency syndrome (AIDS) encephalopathy, human immunodeficiency virus (HIV) encephalopathy, hepatic encephalopathy, Lyme disease encephalopathy including neuroborreliosis, Wernicke's encephalopathy, and systemic lupus erythematosus (SLE) encephalopathy.

- Neurotoxin exposure with at least one of the following:
  - Demonstrated serum levels of neurotoxins
  - Individual with documented significant prenatal alcohol, drug, or toxin exposure

- Seizure disorder, including patients with epilepsy and patients being considered for epilepsy surgery

- Stroke

- Traumatic brain injury (TBI): TBI is defined as a bump, blow, or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

- Neuropsychological testing is unproven and not medically necessary for the following (for more information, see www.unitedhealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Neuropsychological Testing Under the Medical Benefit):
o Baseline neuropsychological testing in asymptomatic persons at risk for sport-related concussions
o Computerized neuropsychological testing when used alone for evaluating concussions
o Neuropsychological testing for the following diagnoses alone without other covered conditions as noted above:
  ▪ Headaches, including migraine headache;
  ▪ History of myocardial infarction;
  ▪ Intermittent explosive disorder.
o Computerized cognitive testing, such as Mindstreams® Cognitive Health Assessment, BrainCareTM and QbTest.

AUTOMATED TESTING AND RESULT

Automated Testing and Result is primarily a method of screening for potentially clinically significant intellectual, cognitive, emotional, and behavioral symptoms or functional deficits that utilizes a single reliable and validated instrument that has automated administration, scoring and interpretation. Automated Testing may also be used to quickly estimate changes in clinical status over time either as a method of obtaining an objective measure of progress in treatment or periodic objective surveillance of known risk issues.

Admission Criteria and Clinical Best Practices
- Automated Testing and Result is within the scope of the provider’s professional training and licensure when the provider is any of the following:
  o A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
  o A masters-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.
    ▪ The masters-degreed provider has professional expertise in the types of tests/assessments being administered.
    ▪ The masters-degreed provider is conducting test administration, scoring and interpretation in accordance with licensing standards and psychological testing professional and ethical standards.
  o A credentialed psychiatrist who meets the following requirements:
    ▪ Recognized certification in neurology through the American Board of Psychiatry and Neurology;
    ▪ Accreditation in behavioral neurology and neuropsychiatry through the American Neuropsychiatric Association;
    ▪ State medical licensure specifically allowing for the provision of neuropsychological testing service(s);
    ▪ Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
    ▪ Physician and supervised psychometrician(s) adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

DEVELOPMENTAL TESTING, ASSESSMENT OF APHASIA, COGNITIVE PERFORMANCE TESTING

- Assessment of Aphasia (96105) is the evaluation of expressive and receptive speech and language function, language comprehension, speech production ability, spelling or writing with interpretation and report per hour. This procedure is often conducted by a speech language therapist. It is not considered a form of psychological testing and is not typically covered under the behavioral health benefit.
- Standardized cognitive performance testing (96125) is an occupational therapy assessment used to assess capacity to function in activities of daily living. It is not considered a form of psychological or neuropsychological testing and is not typically covered under the behavioral health benefit.
- Developmental Testing (96110, 96112, 96113, 96127) is an adjunct to the routine surveillance for developmental delays in young children. This procedure is often conducted by
a developmental pediatrician, or a speech, language, physical or occupational therapist. It is not considered a form of psychological testing, and is not typically covered under the behavioral health benefit.

**PSYCHOSOCIAL REHABILITATION**

Psychosocial rehabilitation (PSR) is comprised of individual face-to-face interventions for the purpose of rehabilitative skills building, the personal development of environmental and recovery supports considered essential in improving a person’s functioning, learning skills to promote the person’s self-access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual.

**Admission Criteria**

- See Common Criteria
- The member’s condition indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:
  - The member has difficult gaining and utilizing necessary functional skills, such as those related to:
    - Education or work;
    - Finances;
    - Housing;
    - Health/medical;
    - Social needs;
    - Basic living skills;
    - Legal needs.

**Continuing Stay Criteria**

- See Common Criteria

**Discharge Criteria**

- See Common Criteria
- The discharge plan:
  - Identifies the member’s progress meeting their rehabilitation goal(s);
  - Identifies the plan for services and supports needed to further assist the member with community integration, recovery, and realizing a higher quality of life;
- Includes information on the continuity of the member’s medications.

**Clinical Best Practices**

- See Common Best Practices
- Services are organized around:
  - The member’s stated goals;
  - The member’s preferences;
  - The identified needs of the member;
  - Improving the member’s ability to understand their needs;
  - Assisting the member with achieving goal, such as:
    - Community living skills, including food planning and preparation, money management, maintenance of living environment, etc.;
    - Interpersonal relations;
    - Recreation or use of leisure time activities;
    - Vocational development or employment;
    - Educational development;
    - Self-advocacy;
    - Access to non-disability related social resources.
- The responsible provider, in conjunction with the rehabilitation team, completes the initial evaluation of the following within 24 hours of admission:
Factors leading the member to access services;
Assessment of harm to self, others, and/or property;
The member’s readiness for rehabilitation;
The member’s overall rehabilitation goal(s);
The member’s functional skills and knowledge in relation to the overall rehabilitation goal(s);
The member’s resources in relation to the overall rehabilitation goal(s).

- The responsible provider, in conjunction with the rehabilitation team and whenever possible, the member, develops a multidisciplinary rehabilitation plan that focuses on the following:
  - The member’s rehabilitation goal(s);
  - The member’s present level of skills and knowledge relative to the rehabilitation goal(s);
  - The skills and knowledge needed to achieve the member’s rehabilitation goal(s);
  - The member’s present resources and the resources needed to achieve the member’s rehabilitation goal.

- The rehabilitation plan includes specific and measurable objectives aimed at assisting the member with achieving the rehabilitation goal(s), and interventions for each skill, knowledge, or resource objective.

- The rehabilitation plan may be informed by the findings of the initial clinical evaluation.

- When the initial assessment identifies a potential risk of harm to self, others, and/or property, a personal 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.

- Service Delivery
  - Restoration, rehabilitation and support of daily functioning to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person’s daily functioning.
  - Supporting the individual with restoration and implementation of daily functioning and daily routines critical to remaining successfully in home, school, work, and community.
  - Rehabilitation and support to restore skills to function in a natural community environment.
  - Eligible providers are unlicensed mental health practitioners in accordance with 5160-27-01 who have at a minimum a high school diploma with mental health training.

- Providers shall adhere to documentation requirements set forth in rules 5160-01-27 and 5160-8-05 of the Administrative Code.

**Limitations and Exclusions**

- PSR will not be reimbursed when a patient is enrolled in the ACT, IHBT, or receiving residential treatment services.
- When TBS group services cannot be billed in combination with any one of the following: mental health day treatment, SUD intensive outpatient group or SUD partial hospitalization group.
- PSR must be delivered as a face-to-face intervention, not in a group setting.

**THERAPEUTIC BEHAVIORAL SERVICES**

Therapeutic Behavioral Services (TBS) are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual’s treatment plan. Solution focused interventions, emotional and behavioral management, and problem behavior analysis includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person’s capacity to cope with or
prevent symptom manifestation. TBS is an individual or group face-to-face intervention with the individual, family/caregiver and/or or other collateral supports.

**Admission Criteria**
- See Common Criteria

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Best Practices
- Service Delivery
  - Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's treatment plan. Activities are including but not limited to the following:
    - Treatment Planning - Participating in and utilizing strengths based treatments/planning which may include assisting the individual and family members or other collaterals with identifying strengths and needs.
    - Identification of strategies or treatment options - Assisting the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness.
    - Counseling - Developing and providing individual supportive counseling including solution focused interventions, emotional and behavioral management, and problem behavior analysis drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions.
    - Restoration of social skills - Rehabilitation and support with the restoration of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies, and promote effective functioning in the individual's social environment including home, work and school.
    - Restoration of daily functioning - Assisting the individual to restore daily functioning specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements; and
    - Crisis prevention and amelioration - Assisting the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location or that result in functional impairments, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or, as appropriate, seeking other supports to restore stability and functioning.

**Limitations and Exclusions**
- TBS will not be reimbursed when a patient is enrolled in the ACT, IHBT, or receiving residential treatment services.
- TBS must be delivered as in individual or group face-to-face intervention with the individual, family/caregiver and/or other collateral supports.
- When TBS group services cannot be billed in combination with any one of the following: mental health day treatment, SUD intensive outpatient group or SUD partial hospitalization group.
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