Mental Health Level of Care Criteria

Reviewed 2024 / Revised 2023

Table of Contents

Reviewed 2024 / Revised 2023

INTRODUCTION

Access Behavioral Health operates in accordance with the Florida Medicaid Coverage and Limitations Handbooks for behavioral health services. This document outlines a description of services, as well as admission, exclusion, continued stay and discharge criteria. ABH provides this information to assist in determining medical necessity and the appropriate level of care for its members in need of services. These are not directives for care. The responsibility for treatment rests with the providers. The provider should always use clinical judgment in making treatment decisions. Member input and preference also play a role in all treatment decisions.

The Level of Care Criteria should be applied based on the Access Behavioral Health Foundations of Treatment. The treatment services envisioned by Access Behavioral Health must be recovery-oriented for adults and promote resiliency in children and be consistent with the principles of recovery. Access Behavioral Health adheres to the following principles in the provision of care:

FOUNDATIONS OF TREATMENT

All care should be delivered within the framework of this basic foundation.

ACCESSIBILITY:

- Services shall be delivered in a timely fashion in the least restrictive, most appropriate environment.
- The provision of services shall be communicated in a language understood by the individual.
- Mental health services are most effective when delivery is within the context of the individual's community.

MEMBER PARTICIPATION:

- The treatment system should promote the dignity and respect of all persons.
- Individual member rights are explained and protected.
- The person directs the recovery process; therefore, the individual's input is essential throughout the treatment process.
- Individuals are encouraged to complete mental health advance directives, and these are to be followed whenever possible.
- Individuals are able to recover more quickly when their hope is encouraged, enhanced, and/or maintained; life roles with respect to work and meaningful activities are defined; spirituality is considered; culture is understood; educational needs as well as those of their family/significant others are identified; and socialization needs are identified.
- Individual differences are considered and valued across the life span.

LINKAGE AND INTEGRATION:

- Family involvement may enhance the recovery process. The individual defines his/her family unit.
- Community involvement as defined by the individual is important to the recovery process.
- Services shall be provided in an integrated manner with the schools, childcare centers, other state agencies, and other community organizations providing services to the individual.

- Services shall be coordinated to address the full range of human needs and provide continuity of care. Continuity of care shall effectively address the coordination of services for members who experience co-occurring illnesses (specifically, mental illness, substance abuse, developmental disorders, or physical illnesses).

TREATMENT EXCELLENCE:

- Service providers must be aware of the tendency to enable individual dependency.
- Recovery is most effective when a holistic approach is considered.
- Medical, psychological, social and recovery models are merged.
- The clinician's initial emphasis on "hope" and the ability to develop trusting relationships influences recovery.
- Clinicians operate from a strengths/assets model.
- Clinicians and the individual/family collaboratively develop an Individualized Treatment Plan. This plan focuses on the interventions that will facilitate recovery and the resources that will support the recovery process.
- For children, services and treatments must be family centered, geared to give family's real and meaningful choices about treatment options and providers. Care must focus on increasing the child's ability to successfully cope with life's challenges and on building resilience, not just on managing symptoms.
- Services shall be based upon an Individualized Treatment Plan with goals, measurable objectives and specific treatment strategies.
- Services related to medication management shall be delivered in a manner consistent with current evidence-based protocol and integrated with other necessary mental health services.
- Treatment, rehabilitative services, and supports will be based on evidence-based protocols whenever possible.
- ABH and the service provider shall not interpret general Medicaid policy but shall refer policy issues to the Medicaid Area Office or the Bureau of Medicaid Services.

COVERED DIAGNOSES

ABH covers both mental health and substance abuse for the following ICD-10 diagnosis codes F01.50 through F53, F55.0 through F63.9, F68.10 through F69, F88 through F99 and Z03.89.

ABH does not authorize community behavioral health services for the treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation. Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

TREATMENT GUIDELINES

ABH adheres to evidence-based guidelines established by the behavioral health community.

http://floridabhcenter.org/
Medicaid Drug Therapy Management Program for Behavioral Health

https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines
Diagnosis-based Treatment Guidelines for Adults

https://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx
Diagnosis-based Treatment Guidelines for Children and Adolescents

MEDICAL NECESSITY and MEDICALLY RECOMMENDED CRITERIA

The need for services is based on the ABH definition of “medical necessity”. Medical Necessity is defined as those services which are determined to:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs.
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

Admission and treatment is based not only on the concept of “medical necessity” but also is, under certain circumstances, approved when felt to be “medically recommended.” ABH considers social objectives as part of its medically recommended utilization management process, especially for individuals with a serious and persistent mental illness, children with special needs due to physical and/or mental illnesses, adults age 65 and older, foster care children, and non-elderly adults who are disabled or chronically ill with developmental or complex physical needs; and understands that often addressing the members social objectives outweighs the risk of recommending a lower level of care. ABH will consider medically recommended criteria on a case-by-case basis. The provider must contact ABH Care Management staff for consultation and authorization.

ASSESSMENT

Prior to the authorization of services, the client must receive an assessment of mental status, functional capacity, strengths and service needs. The purpose of the assessment is to gather information to be used in the formulation of the client’s needs, deficits, diagnosis and development of a plan of care including criteria for discharge.

SERVICE DELIVERY APPROACH: RECOVERY AND RESILIENCE

The Access Behavioral Health approach to treatment is one based on recovery. Recovery is cited the "single most important goal" for the mental health delivery system in Transforming Mental Health Care in America, Federal Action Agenda: First Steps. A national consensus statement has been developed on mental health recovery and is incorporated in the ABH philosophy of service delivery. This statement identifies ten fundamental components of recovery which are outline below.

The ABH service delivery system is focused on fostering recovery and resiliency for its members. Recovery is defined as a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. Resiliency is defined as the ability to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence, and hope. Resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments.

The ABH service delivery system ensures that all members have easy and continual access to needed service. The service delivery system has been designed to make it easy to navigate. Treatments are based on the latest available knowledge to provide optimum care for members and their families and to promote positive clinical outcomes. Members are viewed as partners in the service delivery system. Members have choice of mental health providers, share in the decision-making process and have the option to agree or disagree with the treatment plan. The member's needs and preferences drive the services that are provided.

The Ten Components of Recovery

Self-Direction

Within the ABH service delivery system, members are seen as the leaders of their own recovery. They exercise choice and control over their recovery plan. Service providers help members to optimize autonomy, independence, and control of resources to achieve a self-determined life. Each member defines their own goals and providers help in the design of a unique recovery plan to achieve those goals. Members are partners in the service delivery process. When individuals realize that they can control decisions and actions, they realize that they have the inner resources to cope with life's challenges. Control and coping are crucial elements in fostering resiliency.

Individualized and Person-Centered

Each individual is unique with their own strengths, needs, experiences and preferences. Service provision is based on the uniqueness of the individual and takes into account the person's cultural background. The member is a partner in the treatment process. Their choices are sought and respected. Recovery is an individualized process; therefore, the services needed for recovery must be individualized in order to achieve optimal outcomes. Services are tailored to the needs of the individual instead of the individual being forced into a preset program design. Appropriate treatments and supports are available to the individual and these treatments and supports are oriented toward recovery and resilience. Family involvement in the treatment process is encouraged and sought. Family is defined by the member and not the program.

The individualized plan of care is updated based on the changing needs of the member and family. The plan of care includes treatment, supports and assistance to help the member to better integrate into their community and to realize improved functioning in their life.

Empowerment

ABH members are empowered to participate in all decisions that impact their lives. They are taught and supported in this process by ABH and its providers. ABH members are provided the opportunity of joining with other peers in the Member Action Councils. The Councils provide a forum for members to identify and address their needs. The Council input has been valuable in the design and maintenance of the ABH system of care.

Holistic

The ABH service delivery system recognizes that taking a holistic approach to treatment is what benefits members the most. Individuals are more than their diagnosis and have a wide variety of needs and preferences. Recovery embraces the whole person. Providers of ABH services fully assess the individual and family to help determine what their individual needs are. Services are provided by the network or by referral. Community supports also play a crucial role in the recovery process. Providers are cognizant of services within the Area and educate members on the resources available to them and help them make community connections. Close ties to family, peers, and community give individuals a sense of security and belonging. This sense of connection is one of the foundations in building resilience.

Non-Linear

Recovery does not occur in a straight-line progression. Many factors impact the individual's ability to work a recovery program. Mental illness by its very nature encompasses times of setback and relapse. Each person enters the service delivery system at a different stage of readiness to change. ABH providers assess this readiness and incorporate strategies in the service provision to increase and enhance the member's readiness to change. Working with the member as a partner and working with them at their stage of readiness greatly increases treatment compliance. Improved compliance leads to improved clinical outcomes. The ABH service delivery model includes wellness planning and relapse prevention planning. Increased awareness of these important aspects of recovery has been shown to augment the member's recovery process.

Strengths-Based

The ABH service delivery system is based on the strengths of the individual and their family. Services built around the strengths of a member rather than on their problems and pathologies are more likely to engage the member in the therapeutic process and to encourage them to use their strength and resources. Assessment, treatment planning and services are delivered from a strength-based focus. ABH and its providers prescribed to the philosophy that the failure of a member and/or family to acquire a skill does not equate to the member/family having a deficit. In problem focused systems the member and family are labeled as noncompliant if they do not follow the goals and interventions that have been set for them. In the ABH strength-based system, we recognize that members have to set their own recovery goals and that the service providers then afford them the experiences and instructions needed to master the skills necessary to achieve the goals. A strength-based system of service delivery empowers the member and foster hopes. The member is able to develop new and positive life roles. Strength based service delivery is the foundation on which recovery is based. Competence, the ability to manage situations effectively and confidence, a belief in one's own abilities are cornerstones to fostering resiliency.

Peer Support

Within the ABH service delivery system it is acknowledged that peers play an important role in helping others who are living with mental illness. The mutual support provided by a peer network plays an important role in recovery. ABH and the provider network recognize the importance of peer support in the overall service delivery system. Through peer support members can realize that they too can take action and make choices that improve their community and the world. This helps in the development of a sense of purpose, a building block of resiliency.

Respect

ABH and its providers are committed to protecting member rights. Client rights and responsibilities are outlined in the member handbook given to members upon enrollment in the

plan. When members and their families enter services, these rights are explained to them in a manner understood by the member. Rights are prominently posted in areas where ABH services are provided. Included on these postings are the means to file a grievance with ABH, member advocacy groups, DCF or AHCA if there has been a violation of these rights.

ABH and the providers work within the community to eliminate discrimination and stigma often associated with mental illness. This begins with the way in which members are referred. Members are referred to as individuals and not their illness. Therapists are taught to avoid stigmatizing language which in the past members then used on themselves and identified with, accepted and felt hopeless to change. All service provided is based on the strengths of the individual and family and not pathology. Stigmatizing words such as non-compliant, resistant to treatment, unmotivated, poor insight, oppositional, dysfunctional, unwilling, and calling a person by their diagnosis are avoided.

The diversity of the individual and their family is respected in the ABH service delivery system. Services are delivered in a culturally sensitive and competent manner. Services are adapted to meet the needs of the member instead of the member having to adapt to the needs of a program.

All members regardless of their race, gender, ethnicity, language, age, or place of residence are entitled to receive the highest quality of care available.

Responsibility
One goal of the ABH service delivery system is to help members achieve their highest level of functioning. ABH recognizes that in order to attain this goal the member must assume personal responsibility for their own recovery. Services therefore are designed to not enable members to depend on the system to take care of them and their needs but are designed to allow the member to realize their highest level of independence. Members are taught to identify and enhance their coping and wellness strategies to promote their own recovery and foster resilience.

Hope
Recovery is based on fundamental believe that people are capable of the barriers and obstacles that confront them. Within the ABH service delivery system hope is seen as the catalyst of change and is fostered. The ABH service delivery system focuses on what is and has been successful for the member and their family and builds on these successes to help lay the realistic groundwork for recovery. Often for the first-time members and their families recognize their successes. These building blocks are used to foster positive growth and change.

CULTURAL COMPETENCE

ABH expects services to be provided within a framework of cultural competence. Culture, as defined by the national Child and Adolescent Service System Program (CASSP), is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs. Cultural Competence is a set of congruent practice skills, behaviors, attitudes, and policies that comes together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

The following is from the Substance Abuse and Mental Health Services Administration Evidence-Based Practices statement on cultural competence:

"Cultural competence is about adapting mental health care to meet the needs of members from diverse cultures. One key aim is to improve their access to care. Others are to build trust and to promote their engagement and retention in care.

Above all, cultural competence aims to improve the quality of care and to help members recover quicker and better. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups."

Please refer to CASSP and the complete SAMHSA cultural competency guideline which can be found at the SAMHSA website at www.samhsa.gov. ABH recommends that providers train all staff with direct member contact in the basics of cultural competency.

MENTAL HEALTH ADVANCE DIRECTIVES

Most people are familiar with advanced directives used in medical care, most commonly for end-of-life decisions, but are not as familiar with mental health advanced directives. Access Behavioral Health (ABH) endorses the completion of mental health advance directives by its members and expects service providers to help the member complete this valuable document. For further information please refer to Florida Statutes, Chapter 765.

Advance directives offer a method to members of self-management of their mental health and recovery and are a means of self advocacy. Service providers are to provide members written information concerning advance directives and will document in the medical record whether the member has a mental health advance directive. The member is in no way required to have an advance directive, it is choice offered and explained to them.

A mental health advance directive is a legal document designed to identify a person’s preferences regarding mental health care. The form is completed when a person is not in a mental health crisis, when the person is able to make and understand the choices and decisions being made. The form is then used for direction in treatment choices if the person does experience a mental health crisis. While others may provide input or information to help in this decision-making process, the individual has the final say as to what goes on the final advance directive form.

The mental health advance directive names a surrogate to make mental health decisions for the member in case in the future the person is unable to make such decisions for them self. The surrogate is someone the member trusts to speak and act on the member's behalf. The surrogate should not be a mental health professional, an employee of the facility that is currently providing or might provide services to you, an employee of the Department of Children and Family Service, or a member of the local Advocacy Council.

In order to complete an advance directive, the person must be stable and have the capacity to prepare an advance directive. As long as the member remains competent to make health care decisions, then he/she is the one to do so. Advance directives are only used when the person is incapable of making health care decisions.

Incapacity or incompetence means that a person has been evaluated by a doctor and found to be physically or mentally unable to give well-reasoned, willful and knowing healthcare decisions.

Once a member has been found to be incapable of making health care decisions the surrogate on the advance directive is to be notified to make decisions as outlined on the advance directive. The service provider then petitions the court to have the surrogate appointed as the member's Guardian Advocate.

Service providers must make every effort to comply with the advance directive or treatment decisions of the surrogate. Providers unwilling to comply must make reasonable efforts to transfer the member to another treatment facility that will comply with the directive or treatment decisions.

TELEMEDICINE/TELEHEALTH

Telemedicine/Telehealth is the practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment.

Spoke Site: The provider office location in Florida where an approved service is being furnished through telemedicine.

Hub Site: The telecommunication distance site in Florida at which the consulting physician, dentist or therapist is delivering telemedicine services.

Services must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider for Medicaid to reimburse for services delivered through telemedicine. Services that can be provided through telemedicine are listed in the Medicaid Handbook for Community Behavioral Health Services Procedure Codes and Fee Schedule, found in the appendices. Effective April 2020, under FL Medicaid COVID-19 flexibilities, any service that can reasonably be delivered via a telehealth format is allowed.

The following interactions do not constitute reimbursable telemedicine services:

- Telephone conversations (note: effective April 2020, under FL Medicaid COVID-19 flexibilities, telephone conversations are allowed)
- Video cell phone interactions (note: effective April 2020, under FL Medicaid COVID-19 flexibilities, video cell phone conversations are allowed)
- E-mail messages
- Facsimile transmission

Providers utilizing telemedicine must implement technical written policies and procedures for telemedicine systems that comply with the Health Insurance Portability and Accountability Act privacy regulations as well as applicable state and federal laws that pertain to patient privacy. Policies and procedures must also address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.

Services provided via Telemedicine and Telehealth must adhere to the Agency for Health Care Administration’s (AHCA) *Community Behavioral Health Services Coverage and Limitations Handbook* guidelines and requirements and must only be rendered by a practitioner who meets the AHCA qualifications for that service. Appropriate services codes with the GT or CR modifier and/or place of service code “02” must be used for billing.

Documentation for the service should follow standard documentation protocols and should include justification as to why the service is being provided via Telemedicine and/or Telehealth instead of in person. Telemedicine and/or Telehealth services must be provided to clients in a secure office location. The client must consent in writing to service delivery via Telemedicine and/or Telehealth. The computer used to provide Telemedicine and Telehealth must not be able to access any client records or information. If the member us using an in-facility computer, staff must assist the client with computer operation to ensure proper operation and assist the client if needed to address any computer or other problems, or if the client has questions.

GENERAL ADMISSION CRITERIA

1. Evidence of mental illness
    a. Member has been assessed by trained professional, and
    b. Symptomology meets criteria for covered diagnosis and
    c. Assessment includes DSM 5 diagnoses and
2. The member does not meet admission criteria for a higher/lower level of care

GENERAL EXCLUSION CRITERIA

1. Presenting symptoms are not the result of a covered diagnosis.
2. The primary presenting problem is economic, social, or medical without concurrent acute symptomology of mental illness
3. The following conditions are excluded except where there is a coexisting psychiatric diagnosis with symptoms that meet admission criteria, and it is the psychiatric condition that is the focus of the intervention:
    a. Mental Retardation
    b. Autism
4. The individual/parent/guardian does not give voluntary consent for treatment

GENERAL CONTINUED STAY CRITERIA

1. Treatment planning is individualized to the individual with specific, measurable, and timed goals and objectives
2. Services delivered are supported by clinical and research data to have the expectation of improving the individual's symptoms
3. Need for continued intervention at this level to address lack of progress toward treatment goals or although progress is evident specified goals of treatment have not yet been met
4. A comprehensive discharge plan has been developed that includes specific, behavioral and timed discharge criteria
5. Care is provided in a clinically sound manner

GENERAL DISCHARGE CRITERIA

1. Admission criteria for the current level of care are no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for treatment is withdrawn
5. Ability to control behavior in a less restrictive environment
6. There is no evidence that the individual is at risk for hospitalization, rehospitalization, or readmission to other acute levels of care
7. Level of functioning shows improvement
8. No observed Assaultive or destructive behavior

9. The individual demonstrates the ability to maintain stability with less intensive level of care
10. Support systems are available that allow for a less restrictive placement
11. Physical condition is such that individual is in need of medical attention and needs to be transferred to medical care

COORDINATION OF CARE AND DISCHARGE PLANNING

Provision of care coordination is an important aspect of the treatment process. Care coordination may be provided by direct care staff or by other staff working directly on behalf of the member. As care management is a component of case management, case management services are excluded from this level of care. All care coordination services and activities are documented in the member's clinical record. Care coordination helps with continuity of care for the member and increases the potential for positive outcomes.

Care coordination includes but is not limited to:

- Completing a comprehensive review of the members medical record from another treatment provider for the purpose of assessment and treatment planning
- Coordinating the delivery of all mental health services, including coordination with the primary physical health care provider, associate providers, Department of Children and Families/Community Based Care, the legal system, and community programs and supports
- Coordinating the delivery of optional or community-based services with other agencies and programs involved in the member's care
- Ensuring continuity of care for members who are disenrolled from the Plan
- Collaborating and communicating with providers in ensuring the availability of all support services and resources required by the member
- Assisting the individual transitioning from one level of care to another
- Assisting the individual in transitioning to another service provider
- Referrals to needed services, monitoring outcomes of the referral efforts, and subsequent follow-up
- Assistance provided related to accessing physical health care
- Coordinating on an as needed basis with others regarding information related to the ABH prescribed medication report
- Coordinating care among multiple providers
- Reports to referral source or others
- Consultation with others regarding the care and treatment of the individual
- Outreach efforts on behalf of the individual

SPECIFIC ADMISSION, EXCLUSION, AND DISCHARGE CRITERIA

INPATIENT HOSPITAL PSYCHIATRIC SERVICES: ADULT

Adult inpatient hospital psychiatric services are medically necessary mental health care services provided in a hospital setting. These services are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness which is manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in placing the health of the individual in serious jeopardy.

Medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

SPECIFIC INPATIENT ADMISSION CRITERIA

1. Due to mental illness the individual is likely to suffer from neglect or refuse to care for self to such a degree that the member's well-being is threatened, e.g.
   - A. Severe deficit in self-care
     - a. Fails to maintain minimal personal hygiene
     - b. Fails to take prescribed medications
     - c. Fails to take medications as prescribed
   - B. Refusal/inability to comply with treatment
   - C. Physiological imbalance requiring 24-hour nursing care
     - a. Lack of proper nutrition
     - b. Exhaustion due to extreme hyperactivity
   - D. Impaired thought or perceptual processing
     - a. Paranoia
     - b. Hallucinations, especially command hallucinations directing harm to self or others
     - c. Delusions
   - E. Major impairment in judgment
   - F. Major impairment in communication
   - G. Disordered or bizarre behavior
   - H. Severe psychomotor agitation or retardation that interferes with activities of daily functioning
   - I. Severe side effects from use of psychotropic medications

OR

2. Due to mental illness the individual poses serious threat to self or others
   - A. Threat is accompanied by at least one of the following:
     - a. Major impairment in mood
     - b. Major life stressors
       - i. Interpersonal loss
       - ii. Interpersonal conflict
       - iii. Economic problems
       - iv. Legal problems
       - v. Humiliating event(s)
       - vi. Severe medical problems
     - c. Recent suicide attempt or gesture
     - d. Recent aggression or gesture of aggression
     - e. History of suicide attempt(s) or gesture(s)
     - f. History of aggression

Reviewed 2024 / Revised 2023

g. Recent suicide in family or peer group
h. History of suicide in family or peer group
i. Manic excitation
j. Personality disorders, especially borderline, antisocial, or narcissistic
k. Access to lethal means of harm to self or others
l. Recent significant self-mutilation
m. Significant risk-taking behavior
n. Loss of impulse control
o. Major impairment in functioning in several areas such as work, school or family
p. Disorientation or memory impairment which may endanger the welfare of self or others

B. Verbalization of threats to harm self or others
   a. Verbalization of threats is increasing in intensity
   b. Verbalization of threats is accompanied by gesture
   c. Verbalization of threats is accompanied by plan

AND

4. Additional Criteria
   A. A lower level of care has been assessed as not being appropriate
   B. Due to coexisting disorders inpatient care is necessary
   C. Family/Community concerns
      a. Lack of adequate support or recent loss of significant support/protective factors
      b. Alternative living arrangements do not exist or are inappropriate
      c. Family hampers treatment efforts
      d. Symptoms continue despite treatment at a lower level of care
      e. Family environment is causing escalation of symptoms
      f. Improvement does not occur despite provision of community interventions
      g. Severe behavior prohibits participation at lower level of care

SPECIFIC INPATIENT EXCLUSION CRITERIA

1. Individual does not require 24-hour professional monitoring, supervision and assistance.
2. Individual can be safely and feasible treated at a less intensive and restrictive level of care.
3. Individual is primarily suffering from a medical condition that requires inpatient treatment on a medical/surgical unit.
4. Individual is seeking admission to inpatient treatment primarily for reasons other than medical necessity (e.g., to comply with a court order, to obtain shelter, to deter runaway/truant behavior, to achieve family respite, etc.)

SPECIFIC INPATIENT CONTINUED STAY CRITERIA

1. No lower level of care is appropriate to meet the treatment needs, including an involuntary admission awaiting a probable cause hearing
2. Treatment interventions at inpatient level of care have not been exhausted e.g.:
   A. Psychotropic medication evaluation continues
      a. Initial trial
      b. Medication adjustment
   B. Need for PRN medication more than 2 times per 24 hours and symptoms remain unmanageable/uncontrolled
   C. Psychiatric crisis interventions required
      a. Observation
      b. Safety precautions
         i. Seclusion

ii. Chemical restraints
iii. Physical restraints
iv. Mechanical restraints

3. Assaultive/destructive/threatening behavior
4. Treatment refused

SPECIFIC INPATIENT DISCHARGE CRITERIA

1. Admission criteria for inpatient hospitalization no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Consent for treatment is withdrawn and involuntary criteria are not met or the court has denied involuntary status
4. Ability to control behavior in a less restrictive environment
   A. Not a threat to self or others
   B. Level of functioning shows improvement
   C. No observed Assaultive, destructive, or threatening behavior
   D. No evidence of serious medication side effects
   E. No need for restraints in last 24-48 hours
   F. No suicidal or homicidal ideation or behaviors in last 24-72 hours
   G. Adequate nutritional intake
5. Support systems are available that allow for a less restrictive placement
6. Maximum therapeutic progress has been achieved
7. Treatment goals and objectives have been met to significant degree
8. Physical condition is such that a transfer to a medical facility is required
9. Focus of treatment becomes more related to medical condition or substance abuse than to mental illness

INPATIENT HOSPITAL PSYCHIATRIC SERVICES: CHILD

Child/Adolescent inpatient hospital psychiatric services are medically necessary mental health care services provided in a hospital setting. These services are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness which is manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in placing the health of the individual in serious jeopardy.

Medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

Parental/caregiver involvement is strongly encouraged.

SPECIFIC ADMISSION CRITERIA

1. Evidence of mental illness
2. Due to mental illness member is likely to suffer from neglect or refuse to care for self to such a degree that the member's well-being is threatened, e.g.
    - A. Severe deficit in self-care
        - a. Fails to maintain minimal personal hygiene
        - b. Fails to take prescribed medications
        - c. Fails to take medications as prescribed
    - B. Refusal/inability to comply with treatment
    - C. Physiological imbalance requiring 24-hour nursing care
        - a. Lack of proper nutrition
        - b. Exhaustion due to extreme hyperactivity
    - D. Impaired thought or perceptual processing
        - a. Paranoia
        - b. Hallucinations, especially command hallucinations directing self or other harm
        - c. Delusions
    - E. Major impairment in judgment
    - F. Major impairment in communication
    - G. Disordered or bizarre behavior
    - H. Severe psychomotor agitation or retardation that interferes with activities of daily functioning
    - I. Severe side effects from use of psychotropic medications

        OR
3. Due to mental illness member poses serious threat to self or others
    - A. Threat is accompanied by at least one of the following:
        - a. Major impairment in mood
        - b. Major life stressors:
            - i. Interpersonal loss
            - ii. Recent loss of romantic relationship
            - iii. Interpersonal conflict
            - iv. Economic problems
            - v. Legal problems
            - vi. Humiliating event(s)
            - vii. Severe medical problems

viii. Disciplinary difficulties at school
ix. Family dysfunction
1. Parental separation/divorce
2. Death of parent
3. Family conflict/stress
4. Parental legal problems
5. Family violence, abuse or neglect
6. Family environment is causing escalation of symptoms
7. Instability or disruption in family is escalating
8. Lack of familial support

c. Recent suicide attempt or gesture
d. Recent aggression or gesture of aggression
e. History of suicide attempt(s) or gesture(s)
f. History of aggression
g. Recent suicide in family or peer group
h. History of suicide in family or peer group
i. Manic excitation
j. Personality disorders, especially borderline, antisocial, or narcissistic
k. Access to lethal means of harm to self or others
l. Recent significant self-mutilation
m. Significant risk-taking behavior
n. Loss of impulse control
o. Major impairment in functioning in several areas such as work, school, family, or social
p. Disorientation or memory impairment which may endanger the welfare of self or others

C. Verbalization of threats to harm self or others
i. Verbalization of threats is increasing in intensity
ii. Verbalization of threats is accompanied by gesture
iii. Verbalization of threats is accompanied by plan
AND

4. Additional Criteria
A. A lower level of care is unavailable or inaccessible
B. Due to coexisting disorders inpatient care is necessary
C. Family/Community concerns
a. Lack of adequate support or recent loss of significant support/protective factors
b. Alternative living arrangements do not exist or are inappropriate
c. Family hampers treatment efforts
d. Symptomology continues despite treatment at a lower level of care
e. Family environment is causing escalation of Symptomology
f. Improvement does not occur despite provision of community interventions
g. Severe behavior prohibits participation at lower level of care

SPECIFIC INPATIENT EXCLUSION CRITERIA

1. Individual does not require 24-hour professional monitoring, supervision and assistance.
2. Individual can be safely and feasible treated at a less intensive and restrictive level of care.
3. Individual is primarily suffering from a medical condition that requires inpatient treatment on a medical/surgical unit.
4. Individual is seeking admission to inpatient treatment primarily for reasons other than medical necessity (e.g., to comply with a court order, to obtain shelter, to deter runaway/truant behavior, to achieve family respite, etc.)

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continue to be met
2. No lower level of care is appropriate to meet the treatment needs, including an involuntary admission awaiting a probable cause hearing
3. Treatment interventions at inpatient level of care have not been exhausted e.g.:
   - A. Psychotropic medication evaluation continues
     - a. Initial trial
     - b. Medication adjustment
   - B. Need for PRN medication more than 2 times per 24 hours and symptoms remain unmanageable/uncontrolled
   - C. Psychiatric crisis interventions required
     - a. Observation
     - b. Safety precautions
       - ii. Seclusion
       - iii. Chemical restraints
       - iv. Physical restraints
       - v. Mechanical restraints
     - c. Assaultive/destructive/threatening behavior
     - d. Treatment refused
4. Treatment planning involves family/guardian

SPECIFIC DISCHARGE CRITERIA

1. Involuntary criteria are not met, or the court has denied involuntary status
2. Ability to control behavior in a less restrictive environment
   - A. Not a threat to self or others
   - B. No evidence of serious medication side effects
   - C. No need for restraints in last 24-48 hours
   - D. No suicidal or homicidal ideation or behaviors in last 24-72 hours
   - E. Adequate nutritional intake
3. Support systems are available that allow for a less restrictive placement
   - A. Family involved in discharge planning
   - B. Family education regarding mental illness and medication provided
   - C. Family demonstrates willingness/ability to obtain any needed follow-up services

CRISIS STABILIZATION UNIT SERVICES: ADULT

Adult Crisis Stabilization services are medically necessary mental health care services provided in a non-hospital setting. These services are required to meet the needs of an individual who is experiencing a mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in placing the health of the individual in serious jeopardy.

SPECIFIC ADMISSION CRITERIA

1. Evidence of mental illness
2. Due to mental illness member is likely to suffer from neglect or refuse to care for self to such a degree that the member's well-being is threatened, e.g.
   - A. Severe deficit in self-care
     - a. Fails to maintain minimal personal hygiene
     - b. Fails to take prescribed medications
     - c. Fails to take medications as prescribed
   - B. Refusal/inability to comply with treatment
   - C. Physiological imbalance requiring 24-hour nursing care
     - a. Lack of proper nutrition
     - b. Exhaustion due to extreme hyperactivity
   - D. Impaired thought or perceptual processing
     - a. Paranoia
     - b. Hallucinations, especially command hallucinations directing self or other harm
     - c. Delusions
   - E. Major impairment in judgment
   - F. Major impairment in communication
   - G. Disordered or bizarre behavior
   - H. Severe psychomotor agitation or retardation that interferes with activities of daily functioning
   - I. Severe side effects from use of psychotropic medications

OR

3. Due to mental illness member poses serious threat to self or others
   - A Threat is accompanied by at least one of the following:
     - a. Major impairment in mood
     - b. Major life stressors
       - i. Interpersonal loss
       - ii. Interpersonal conflict
       - iii. Economic problems
       - iv. Legal problems
       - v. Humiliating event(s)
       - vi. Severe medical problems
     - c. Recent suicide attempt or gesture
     - d. Recent aggression or gesture of aggression
     - e. History of suicide attempt(s) or gesture(s)
     - f. History of aggression
     - g. Recent suicide in family or peer group
     - h. History of suicide in family or peer group
     - i. Manic excitation
     - j. Personality disorders, especially borderline, antisocial, or narcissistic

Reviewed 2024 / Revised 2023

k. Access to lethal means of harm to self or others
l. Recent significant self-mutilation
m. Significant risk-taking behavior
n. Loss of impulse control
o. Major impairment in functioning in several areas such as work, school or family
p. Disorientation or memory impairment which may endanger the welfare of self or others

B. Verbalization of threats to harm self or others
a. Verbalization of threats is increasing in intensity
b. Verbalization of threats is accompanied by gesture
c. Verbalization of threats is accompanied by plan
AND

4. Additional Criteria
A. A lower level of care is unavailable or inaccessible
B. Due to coexisting disorders inpatient care is necessary
C. Family/Community concerns
a. Lack of adequate support or recent loss of significant support/protective factors
b. Alternative living arrangements do not exist or are inappropriate
c. Family hampers treatment efforts
d. Symptomology continues despite treatment at a lower level of care
e. Family environment is causing escalation of Symptomology
f. Improvement does not occur despite provision of community interventions
g. Severe behavior prohibits participation at lower level of care

SPECIFIC INPATIENT EXCLUSION CRITERIA

1. Individual does not require 24-hour professional monitoring, supervision and assistance.
2. Individual can be safely and feasible treated at a less intensive and restrictive level of care.
3. Individual is primarily suffering from a medical condition that requires inpatient treatment on a medical/surgical unit.
4. Individual is seeking admission to inpatient treatment primarily for reasons other than medical necessity (e.g., to comply with a court order, to obtain shelter, to deter runaway/truant behavior, to achieve family respite, etc.)

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continue to be met
2. No lower level of care is appropriate to meet the treatment needs, including an involuntary admission awaiting a probable cause hearing
3. Treatment interventions at inpatient level of care have not been exhausted e.g.:
A. Psychotropic medication evaluation continues
a. Initial trial
b. Medication adjustment

B. Need for PRN medication more than 2 times per 24 hours and symptoms remain unmanageable/uncontrolled

C. Psychiatric crisis interventions required
a. Observation
b. Safety precautions
i. Seclusion
ii. Chemical restraints
iii. Physical restraints
iv. Mechanical restraints

    c. Assaultive/destructive/threatening behavior
    d. Treatment refused
4. Treatment planning is individualized to the individual with specific, measurable, and timed goals and objectives
5. Services delivered are supported by clinical and research data to have the expectation of improving the individual's symptoms
6. Need for continued intervention at this level to address lack of progress toward treatment goals or although progress is evident specified goals of treatment have not yet been met
7. A comprehensive discharge plan has been developed that includes specific, behavioral and timed discharge criteria
8. Care is provided in a clinically sound manner

SPECIFIC DISCHARGE CRITERIA

1. Involuntary criteria are not met, or the court has denied involuntary status
2. Ability to control behavior in a less restrictive environment
    A. Not a threat to self or others
    B. No evidence of serious medication side effects
    C. No need for restraints in last 24-48 hours
    D. No suicidal or homicidal ideation or behaviors in last 24-72 hours
    E. Adequate nutritional intake
4. Focus of treatment is no longer on the mental illness

CRISIS STABILIZATION UNIT SERVICES: CHILD

Child/adolescent Crisis Stabilization services are medically necessary mental health care services provided in a non-hospital setting. These services are required to meet the needs of an individual who is experiencing a mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in placing the health of the individual in serious jeopardy.

SPECIFIC ADMISSION CRITERIA

1. Evidence of mental illness
2. Due to mental illness member is likely to suffer from neglect or refuse to care for self to such a degree that the member's well-being is threatened, e.g.
    A. Severe deficit in self-care
        a. Fails to maintain minimal personal hygiene
        b. Fails to take prescribed medications
        c. Fails to take medications as prescribed
    B. Refusal/inability to comply with treatment
    C. Physiological imbalance requiring 24-hour nursing care
        a. Lack of proper nutrition
        b. Exhaustion due to extreme hyperactivity
    D. Impaired thought or perceptual processing
        a. Paranoia
        b. Hallucinations, especially command hallucinations directing self or other harm
        c. Delusions
    E. Major impairment in judgment
    F. Major impairment in communication
    G. Disordered or bizarre behavior
    H. Severe psychomotor agitation or retardation that interferes with activities of daily functioning
    I. Severe side effects from use of psychotropic medications

        OR
3. Due to mental illness member poses serious threat to self or others
    A. Threat is accompanied by at least one of the following:
        a. Major impairment in mood
        b. Major life stressors
        a. Interpersonal loss
        b. Recent loss of romantic relationship
        c. Interpersonal conflict
        d. Economic problems
        e. Legal problems
        f. Humiliating event(s)
        g. Severe medical problems
        h. Disciplinary difficulties at school
            i. Family dysfunction
            ii. Parental separation/divorce
            iii. Death of parent
            iv. Family conflict/stress
            v. Parental legal problems
            vi. Family violence, abuse or neglect
            vii. Family environment is causing escalation of symptoms

viii. Instability or disruption in family is escalating
ix. Lack of familial support

i. Recent suicide attempt or gesture
j. Recent aggression or gesture of aggression
k. History of suicide attempt(s) or gesture(s)
l. History of aggression
m. Recent suicide in family or peer group
n. History of suicide in family or peer group
o. Manic excitation
p. Personality disorders, especially borderline, antisocial, or narcissistic
q. Access to lethal means of harm to self or others
r. Recent significant self-mutilation
s. Significant risk-taking behavior
t. Loss of impulse control
u. Major impairment in functioning in several areas such as work, school, family, or social
v. Disorientation or memory impairment which may endanger the welfare of self or others

B. Verbalization of threats to harm self or others
a. Verbalization of threats is increasing in intensity
b. Verbalization of threats is accompanied by gesture
c. Verbalization of threats is accompanied by plan

AND

4. Additional Criteria
A. Due to coexisting disorders inpatient care is necessary
B. Family/Community concerns
a. Lack of adequate support or recent loss of significant support/protective factors
b. Alternative living arrangements do not exist or are inappropriate
c. Family hampers treatment efforts
d. Symptomology continues despite treatment at a lower level of care
e. Family environment is causing escalation of symptomology
f. Improvement does not occur despite provision of community interventions
g. Severe behavior prohibits participation at lower level of care

SPECIFIC INPATIENT EXCLUSION CRITERIA

1. Individual does not require 24-hour professional monitoring, supervision and assistance.
2. Individual can be safely and feasible treated at a less intensive and restrictive level of care.
3. Individual is primarily suffering from a medical condition that requires inpatient treatment on a medical/surgical unit.
4. Individual is seeking admission to inpatient treatment primarily for reasons other than medical necessity (e.g., to comply with a court order, to obtain shelter, to deter runaway/truant behavior, to achieve family respite, etc.)

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continue to be met
2. No lower level of care is appropriate to meet the treatment needs, including an involuntary admission awaiting a probable cause hearing
3. Treatment interventions at inpatient level of care have not been exhausted e.g.:
A. Psychotropic medication evaluation continues
a. Initial trial

b. Medication adjustment

B. Need for PRN medication more than 2 times per 24 hours and symptoms remain unmanageable/uncontrolled

C. Psychiatric crisis interventions required
   a. Observation
   b. Safety precautions
      i. Seclusion
      ii. Chemical restraints
      iii. Physical restraints
      iv. Mechanical restraints
   c. Assaultive/destructive/threatening behavior
   d. Treatment refused

4. Treatment planning involves family/guardian

SPECIFIC DISCHARGE CRITERIA

1. Involuntary criteria are not met, or the court has denied involuntary status
2. Ability to control behavior in a less restrictive environment
   A. Not a threat to self or others
   B. No evidence of serious medication side effects
   C. No need for restraints in last 24-48 hours
   D. No suicidal or homicidal ideation or behaviors in last 24-72 hours
   E. Adequate nutritional intake
3. Support systems are available that allow for a less restrictive placement
4. Family involved in discharge planning
5. Family education regarding mental illness and medication provided
6. Family demonstrates willingness/ability to obtain any needed follow-up services
7. Focus of treatment is no longer on the mental illness

BEHAVIORAL HEALTH DAY SERVICES: ages 24 months through 5 years

Behavioral health day services are appropriate therapeutic services for children aged 24 months and older who are experiencing emotional problems. Services provided in the treatment milieu allow for a broad range of therapeutic activities designed for the treatment of specific social, emotional, and behavioral problems.

Services are designed to strengthen individual and family functioning, prevent more restrictive placement, and to provide an integrated set of interventions to promote behavioral and emotional adjustment.

Services must be delivered in a coordinated manner and must be appropriate for the developmental age of the child. Services must be individualized and directly related to the treatment plan goals and the long-term goal of returning the child to regular daycare, preschool, or the least restrictive environment possible.

Services are provided in a therapeutic milieu and are not just for custodial care, basic childcare or enrichment. The purpose of the behavioral health day services must be to address the young child's emotional problems.

Services must be provided for a minimum of two hours to a maximum of four hours within the day. This need not be a continuous time period but must be provided in one day. At least one hour of therapeutic activities, as listed on the child's treatment plan, must be interwoven throughout the child's scheduled activities.

The behavioral health day program must include a parent or caregiver component.

Services delivered in the behavioral heath day program are supported by clinical and research data to have the expectation of improving the child's symptoms and level of functioning.

The treatment providers must have 20 hours of specific training, documented in their personnel record, in working with children 0 through 5 years of age, prior to the delivery of service to this population. Staff must be able to identify normal developmental behaviors.

Each child must, within 45 days of admission to the behavioral health day services, have a written plan containing specific criteria for discharge from behavioral health day services.

SPECIFIC ADMISSION CRITERIA

Prior to the receipt of behavioral health day services, a physician or other licensed practioner of the healing arts must provide written certification that:

1. The child is 24 months to 5 years of age
2. The child has scored in at least the moderate impairment range on a behavior and functional rating scale developed for this age group
3. The behavioral health day services can be expected to retard deterioration, maintain, or improve the child's condition and functional level
4. The child's condition or functional level cannot be improved in a less restrictive level of care

And

   A. Written justification is provided in the medical record to support the certification of eligibility for behavioral health day services And
   B. The Symptomology can be safely treated at this level of care And
      a. A current assessment has been completed that includes:

b. Presenting symptoms and behaviors
c. Developmental and medical history
d. Family psychosocial and medical history
e. Family functioning, cultural and communication patterns, and current environmental conditions and stressors
f. Clinical interview with primary caregiver and observation of the caregiver-child relationship and interactive patterns
g. Provider's observation and assessment of the child
h. An integrated summary

SPECIFIC EXCLUSION CRITERIA

1. The parent/caregiver does not give voluntary consent for treatment
2. The individual is in need of more structure and supervision than is offered by the day treatment program

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Within at least six months of admission of admission and every six months thereafter the treatment members must provide written documentation that the child continues to meet admission criteria as outlined above
2. Treatment interventions are not exhausted at this level of care
3. Exclusion/discharge criteria are not met
4. Referral is made as appropriate for psychiatric evaluation and medication management
5. Family/caregiver involvement and education regarding mental illness is provided

SPECIFIC DISCHARGE CRITERIA

1. Discharge plan has been met
2. The individual/family refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record
3. The individual/family refuses to follow program rules and regulations to such a degree that continued treatment at this level of care is ineffective and/or unsafe

BEHAVIORAL HEALTH DAY SERVICES: ages 6 through 20

Behavioral Health Day Services (BHDS) are designed to enable individuals to function successfully in the community in the least restrictive environment and to restore or enhance ability for personal, social and pre-vocational life management services.

The primary functions of BHDS are:
1. Stabilization of symptoms related to mental illness
2. To reduce or eliminate the need for more intensive levels of care
3. To provide transitional treatment after an acute episode
4. To provide a level of therapeutic intensity not possible in a traditional outpatient setting

Services are provided in a therapeutic milieu and are not just for custodial care. The approach must take into consideration the child's developmental level and delays in development due to emotional disorders. If the child is school age, the services must be coordinated with the school system.

Caregiver participation and involvement is required.

BHDS are to be provided for a minimum of two hours per day. This need not be a continuous time period but must be provided in one day. At least one hour per day must consist of individual, group, or family services or a combination of these. Services are provided in a therapeutic milieu and are not just for custodial care.

Documentation of BHDS includes a description of the clinical service(s) provided as well as the client's response to the service, with a focus on measurable outcomes and overall progress toward treatment goals.

Services delivered in the BHDS program are supported by clinical and research data to have the expectation of improving the individual's symptoms.

SPECIFIC ADMISSION CRITERIA

1. Evidence of mental illness
   A. The individual is enrolled in a special education program for the seriously emotionally disturbed or emotionally handicapped AND
2. Documentation in the medical record clearly supports that:
   A. The individual meets the eligibility criteria outlined in Section 1 and
   B. The services are medically necessary for the treatment of the individual's mental health
   C. The individual displays disabling psychiatric symptoms or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal. social, vocational, or educational functioning and
   D. The services can be expected to retard deterioration, maintain, or improve the individual's condition and functional level and
   E. The individual's condition and functional level cannot be improved in a less restrictive level of care and
3. The individual is in need of structure for activities of daily living and
4. There is a reasonable expectation that the individual can benefit from therapeutic interactions at this level of care and
5. The individual's Symptomology can be safely and effectively managed at this level of service

SPECIFIC EXCLUSION CRITERIA

1. The individual/parent does not give voluntary consent for treatment

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. Referral is made as appropriate for psychiatric evaluation and medication management

SPECIFIC DISCHARGE CRITERIA

1. Maximum therapeutic progress has been achieved
2. The individual/family refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record
3. The individual/family refuses to follow program rules and regulations to such a degree that continued treatment at this level of care is ineffective and/or unsafe

BEHAVIORAL HEALTH DAY SERVICES: ages 21 and older

Behavioral Health Day Services (BHDS) are designed to enable individuals to function successfully in the community in the least restrictive environment and to restore or enhance ability for personal, social and pre-vocational life management services.

The primary functions of BHDS are:

- Stabilization of symptoms related to mental illness
- To reduce or eliminate the need for more intensive levels of care
- To provide transitional treatment after an acute episode
- To provide a level of therapeutic intensity not possible in a traditional outpatient setting

BHDS are to be provided for a minimum of two hours per day. This need not be a continuous time period but must be provided in one day. At least one hour per day must consist of individual, group, or family services or a combination of these. Services are provided in a therapeutic milieu and are not just for custodial care.

Documentation of BHDS includes a description of the clinical service(s) provided as well as the client's response to the service, with a focus on measurable outcomes and overall progress toward treatment goals.

Services delivered in the BHDS program are supported by clinical and research data to have the expectation of improving the individual's symptoms.

SPECIFIC ADMISSION CRITERIA

All of the following must be in evidence to meet this level of care:

1. Evidence of mental illness based on an assessment of the individual that includes:
   A. Mental status
   B. Functional capacity
   C. Strengths
   D. Service needs
   E. DSM diagnoses
   F. Plan of care
   G. Criteria for discharge
2. Documentation in the medical record clearly supports:
   A. BHDS are medically necessary for the treatment of the individual's mental illness
   B. The individual displays disabling psychiatric symptoms or clinical symptoms of sufficient severity to cause significant impairment in day-to-day personal, social, vocational, and/or educational functioning
3. BHDS can be expected to retard deterioration, maintain, or improve the individual's condition and functional level
4. The individual's condition and functional level cannot be improved in a less restrictive level of care
5. The individual's Symptomology can be safely and effectively treated at this level of care
6. There is reasonable expectation that the individual can benefit from therapeutic interventions at this level of care
7. The individual's Symptomology can be safely and effectively treated at this level of care

SPECIFIC EXCLUSION CRITERIA

Any of following excludes the individual from treatment at this level of care:

1. Treatment can safely and effectively be provided at a lower level of care

2. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
3. There is no documented evidence that symptoms are the result of mental illness
4. Admission to the BHDS setting is being used as an alternative to incarceration and Symptomology of mental illness does not meet criteria for this level of care
5. The primary presenting problem is economic, social, or medical without concurrent acute Symptomology of mental illness
6. The individual does not give voluntary consent for treatment, unless there is a court commitment.
7. The individual is in need of more structure and supervision than is offered by the BHDS program
8. Medical conditions or impairments are present that would prevent participation at this level of care
9. The individual is in a nursing home

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Within at least six months of admission of admission and every six months thereafter the treatment members must provide written documentation that the individual continues to meet admission criteria as outlined above
2. The individual needs can not be better met by either a higher or less intensive level of care
3. Services are individualized and directly related to the treatment plan goals and the individual's/family's long-term goals for residential, social and other life domains
4. The current treatment plan goals and objectives (specific, measurable and timed) are best met at this level of care
5. Need for continued intervention at this level to address lack of progress toward treatment goals or although progress is evident, specified goals of treatment have not yet been met
6. A comprehensive discharge plan has been developed that includes specific, behavioral, and timed discharge criteria
7. Further behavioral health day services can reasonable be expected to retard deterioration, maintain, or improve the individual's condition and functional level
8. Need for continued behavioral health day services to work toward completion of treatment goals
9. Treatment interventions are not exhausted at this level of care
10. Exclusion/discharge criteria are not met
    A. Treatment planning is individualized with specific, measurable, and timed goals and objectives
    B. Care is provided in a clinically sound manner
    C. Referral is made as appropriate for psychiatric evaluation and medication management
    D. Family/caregiver involvement and education regarding mental illness provided as appropriate

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for BHDS no longer met
2. Admission criteria for a lower level of care are met and the service is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for treatment is withdrawn (unless there is a court commitment)
5. Ability to control behavior in a less restrictive environment
    A. There is no evidence that the individual is at risk for hospitalization, re-hospitalization, or readmission to other acute levels of care

   B. level of functioning shows improvement
   C. no observed Assaultive or destructive behavior
   D. the individual demonstrates the ability to maintain stability with less intensive level of care
6. Support systems are available that allow for a less restrictive placement
7. Maximum therapeutic progress has been achieved
8. Treatment goals and objectives have been met to a significant degree
9. Discharge plan criteria are met, and no further treatment goals or objectives are being addressed
10. Physical condition is such that individual is unable to participate in BHDS
11. The individual refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record
12. The individual refuses to follow program rules and regulations to such a degree that continued treatment at this level of care is ineffective and/or unsafe

THERAPEUTIC BEHAVIORAL ON-SITE SERVICES: CHILD

Therapeutic behavioral on-site services are designed to assist children who have complex needs and their families in an effort to prevent the need for a more intensive, restrictive behavioral health placement. The process must be driven by assessment of the individual needs and strengths of each child and family and be developed and directed by a treatment team.

The treatment team must include the child and family, other persons who provide natural, informal support to the family system and the professionals involved in providing services. The child-specific plan for therapeutic behavioral on-site services must be based on a thorough assessment, with input from the child and family, regarding needs, strengths and desired outcomes of services.

When indicated by the assessment, and agreed to by the family, the plan must reflect referral to, and coordination with, other agencies and resources. It is recognized that involvement of the family in the treatment of the child or adolescent is necessary and appropriate. Provision of therapeutic behavioral onsite services with the family must clearly be directed toward meeting the identified treatment needs of the child or adolescent.

If the assessment indicates a need for intensive, clinical therapeutic behavioral on-site services, and the family agrees to these services, the following services are available:

- Therapeutic behavioral on-site – therapy services
- Therapeutic behavioral on-site – behavior management services
- Therapeutic behavioral on-site – therapeutic support services

Therapeutic behavioral on-site therapy services include the following*:*

- Strength-based, clinical assessment of the mental health, substance abuse, or behavioral disorders in order to evaluate, define, and delineate treatment needs.
- Individual and family therapy as agreed to by the child and family.
- Assessment and engagement of the child or adolescent and family's natural support system to assist in implementation of the treatment plan; and
- Development, implementation, and monitoring of behavior programming for the child or adolescent.

Therapeutic behavioral on-site behavior management services include the following:

- Assessment of behavior problems, and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the client's behaviors and the interactions that motivate, maintain or improve behavior.
- Develop an individual behavior plan with measurable goals and objectives.
- Training caregivers and other involved persons in the implementation of the behavior plan.
- Monitoring the child and caregiver progress and revise as needed; and
- Coordinate services on the treatment plan with the treatment team.

Therapeutic behavioral on-site therapeutic support services must be related to the child's or adolescent's treatment plan goals and objectives and must include one or more of the following services:

- One-to-one supervision and intervention with the child or adolescent during therapeutic activities in accordance with the child's treatment plan.

- Skill training of the child or adolescent for restoration of those basic living and social skills necessary to function in the child or adolescent's own environment; or
- Assistance to the child or adolescent and family in implementing the behavioral goals identified through family counseling and development of the treatment plan.

SPECIFIC ADMISSION CRITERIA

1. Is under the age of 21
2. Has a covered ICD-10 diagnosis code: F01.50 through F53, F55.0 through F63.9, F68.10 through F69, F88 through F99 and Z03.89; and
3. Is enrolled in a special education program for the seriously emotionally disturbed or the emotionally handicapped; or
4. Has a covered ICD-10 diagnosis code: F01.50 through F53, F55.0 through F63.9, F68.10 through F69, F88 through F99 and Z03.89; and
    A. There is adequate documentation to indicate that the child is at risk of a more intensive level of care; and
    B. There is adequate documentation to indicate that the child's condition and functional level cannot be improved with a less intensive level of care; and
    C. Written certification is completed by a qualified licensed professional that the child meets admission criteria; and
    D. The services can be expected to retard deterioration, maintain, or improve the child's condition and functional level

SPECIFIC EXCLUSION CRITERIA

1. Treatment can safely and effectively be provided at a lower level of care
2. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
3. The environment in which TBOSS is being offered (and there being no other alternative treatment sites) poses significant and serious immediate risk to staff providing the service
4. The parent/guardian does not give voluntary consent for treatment
5. The individual is in need of more structure and supervision than is offered by the TBOSS program

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual needs can not be better met by either a higher or less intensive level of care
3. Services delivered are supported by clinical and research data to have the expectation of improving the individual's symptoms
4. Care is provided in a clinically sound manner
5. Referral is made as appropriate for psychiatric evaluation and medication management
6. The child and family are participating in the offered services to the degree to which they are able

SPECIFIC DISCHARGE CRITERIA

1. Maximum therapeutic progress has been achieved
2. Treatment goals and objectives have been met to significant degree
3. Physical condition is such that the individual is unable to participate in day treatment services
4. The individual/family refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record

5. The individual/family refuses to follow program rules and regulations to such a degree that continued treatment at this level of care is ineffective and/or unsafe

OUTPATIENT TREATMENT: ADULT/CHILD

Outpatient treatments are those individualized treatment services that are offered in an office, clinic, the individual's home, or other appropriate locations. Outpatient services include the provision of insight oriented, cognitive behavioral or supportive therapy to an individual or family. Services are provided for the maximum reduction of the individual's mental health disability and restoration to the best possible functional level. Outpatient services are expected to improve the individual's condition or prevent further regression. Services include but are not limited to group, individual, family and psycho-educational sessions. Frequency and length of services will vary according to the individual needs of the recipient as outlined on the treatment plan, but should take into account the age, developmental level and the level of functioning of the individual.

SPECIFIC ADMISSION CRITERIA

1. There is reasonable expectation that the individual will be able to respond to intervention at this level of care, and
2. There are symptoms of impairment in at least one life area.
3. Supportive therapies may be medically recommended to prevent the need for more intensive level for some individuals.

SPECIFIC EXCLUSION CRITERIA

1. The individual is assessed as needing a more structured program than is offered in the outpatient setting and:
   A. Such a program is available to the individual
   B. Such a program is assessable to the individual
2. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
3. The individual or the parent /legal guardian if the individual is under 18, does not give voluntary consent for treatment, unless there is a court commitment
4. The individual is in need of more structure and supervision than is offered by this level of care

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual's needs can not be better met by either a higher or lesser level of care
3. Need for continued intervention at this level of service is required to address lack of progress toward treatment goals or although progress is evident, specified goals of treatment have not yet been met
4. Referral is made as appropriate for psychiatric evaluation and medication management
5. Continued intervention at this level of care is necessary to alleviate identified problems
6. Continued intervention at this level of care is required to maintain the individual so that the risk of needing a higher level of service is reduced
7. Individual/caregiver is provided information and education regarding the individual's mental illness and the means to cope with this in the home environment

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for outpatient treatment services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for treatment is withdrawn (unless there is a court commitment)

5. Level of functioning shows improvement
6. No reported Assaultive or destructive behavior
7. Maximum therapeutic progress has been achieved
8. Treatment goals and objectives have been met to a significant degree
9. The individual/family refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record

OUTPATIENT MEDICAL SERVICES: ADULT/CHILD

Outpatient medical and psychiatric services are medically necessary interventions that are provided by a psychiatrist, physician, psychiatric ARNP, or a physician assistant. These services include: evaluation of the need for medication; evaluation of clinical effectiveness and side effects of medication; prescribing, dispensing, and administering of psychiatric medications; medication education (including discussing risks, benefits and alternatives with the individual or other responsible persons); planning related to service delivery; and evaluating the status of the individual's community functioning. Medication management services may be provided face-to-face or via telemedicine.

The following services are included under medical and psychiatric services:

Psychiatric Evaluation:

A psychiatric evaluation is a comprehensive evaluation that investigates the individual's clinical status including the presenting problem; the history of the present illness; previous psychiatric history, physical history, and medication history; relevant personal, and family medical history; personal strengths; and a brief mental status examination. This examination concludes with a summary of findings, diagnostic formulation, and treatment recommendations.

A psychiatric evaluation should be conducted at the onset of illness or suspected illness or when the individual first presents for treatment. It may be utilized again if an extended hiatus occurs, a marked change in mental status occurs, or admission or readmission to an inpatient setting for a psychiatric illness is being considered or occurs.

Provision of a psychiatric evaluation is not considered necessary when the recipient has a previously established diagnosis of organic brain disorder (dementia) unless there has been a change in mental status requiring an evaluation to rule-out additional psychiatric or neurological processes that may be treatable.

Psychiatric evaluations must be provided by a psychiatrist, other physician, or psychiatric ARNP.

Psychiatric Review of Records:

Psychiatric review of records includes the review of the recipient records, psychiatric reports, psychometric or projective tests, clinical and psychological evaluation data for diagnostic use in evaluating and planning for recipient care. A written report must be done by the individual rendering service and must be included in the recipient's medical record.

Psychiatric review of records does not include a review of the provider agency's own records except for psychological testing and other evaluations, or evaluative data used explicitly to address documented diagnostic questions.

This service may not be billed for review of lab work (see medication management).

A psychiatrist or other physician, or psychiatric ARNP, at a minimum, must render psychiatric review of records.

Medication Management:

Medication management is the review of relevant laboratory test results, prior pharmacological interventions (i.e., medication dosages, blood levels if available, and treatment duration), and

current medication usage. Medication management includes the discussion of indications and contraindications for treatment, risks, and management strategies with the recipient or other responsible persons.

Medication management must be provided, at a minimum, by a psychiatrist, other physician, physician assistant, or psychiatric ARNP.

Brief Individual Medical Psychotherapy:
Brief individual medical psychotherapy is treatment activity designed to reduce maladaptive behaviors related to the recipient's behavioral health disorder, to maximize behavioral self-control, or to restore normalized functioning and more appropriate interpersonal and social relationships. Brief medical psychotherapy includes insight oriented, cognitive behavioral, or supportive therapy.

Brief individual medical psychotherapy must be provided, at a minimum, by a psychiatrist or other physician, physician assistant, or psychiatric ARNP.

Group medical therapy:
Group medical therapy is a treatment activity designed to reduce maladaptive behaviors; maximize behavioral self-control; or to restore normalized functioning, reality orientation and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. This service includes continuing medical diagnostic evaluation and drug management, when indicated, and may include insight oriented, cognitive behavioral, or supportive therapy.

Group medical therapy must be personally rendered by a psychiatrist or psychiatric ARNP.

Behavioral Health Screening Service:
A behavioral health screening service must include a face-to-face assessment of physical status, a brief history, and decision-making of low complexity. Results of the examination must be included in the recipient's medical record. The assessment must include, at a minimum:

- Vital signs.
- Medication concerns to include side effects.
- Brief mental status assessment; and
- Plan for follow-up, if indicated.

Behavioral health screening services must be provided, at a minimum, by a psychiatrist, other physician, physician assistant, ARNP or registered nurse.

Behavioral Health Services:
Behavioral health services are outpatient services provided to persons with a behavioral health illness. This procedure covers the following services:

- Specimen collection, taking of vital signs, administering injections; or
- A verbal interaction (15-minute minimum) between the practitioner and recipient.

This service must be directly related to the recipient's behavioral health disorder or to monitoring side effects associated with medication.

Specimen collection, taking vital signs, administering injections must be provided by an individual qualified by his professional licensure, training, protocols and competence and within the purview of statutes applicable to his profession.

Verbal interaction must be provided, at a minimum, by a physician's assistant, ARNP, or R.N.

ADMISSION CRITERIA

1. Evidence of mental illness
   A. Member has been assessed by a trained professional(s) and
   B. Symptomology meets criteria for a DSM covered diagnoses and
   C. Assessment includes DSM diagnosis and
2. Documentation in the medical record clearly supports that:
   A. The individual meets the eligibility criteria outlined in Section 1 and
   B. The services are medically necessary for the treatment of the individual's mental health and
   C. The individual displays disabling psychiatric symptoms or clinical conditions of sufficient severity to require medical intervention and
   D. The services can be expected to retard deterioration, maintain, or improve the individual's condition and functional level and
   E. The individual's condition and functional level is not likely to improve without medical intervention AND
3. There is a reasonable expectation that the individual can benefit from therapeutic interactions at this level of care AND
4. The individual's Symptomology can be safely and effectively treated at this level of care

EXCLUSION CRITERIA

1. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
2. The individual, or the child's parent/legal guardian does not give voluntary consent for treatment
3. Medical conditions or impairments are present that would prevent psychiatric medical intervention

CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual needs can not be better met by either a higher or less intensive level of care
3. Services delivered are supported by clinical and research data to have the expectation of improving the individual's symptoms
4. Care is provided in a clinically sound manner
5. Referral is made as appropriate for general medical evaluation and medication management
6. Continued intervention at this level of care is necessary to alleviate identified symptoms
7. Continued intervention at this level of care is required to maintain the individual so that the risk of needing a higher level of service is reduced
8. Education regarding the prescribed medications is given to the individual/family

DISCHARGE CRITERIA

1. Admission criteria no longer met
2. Admission criteria for a more acute level of care are met
3. Consent for treatment is withdrawn

4. The individual demonstrates the ability to maintain stability without the use of medical intervention
5. Physical condition is such that individual is unable to participate in psychiatric medical services
6. The individual or the child's parent/legal guardian refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record
7. The individual/family refuses to follow program rules and regulations to such a degree that continued treatment at this level of care is ineffective and/or unsafe

PSYCHOSOCIAL REHABILIITATION: ADULT/CHILD

Psychosocial rehabilitation services may be provided in a facility, home, or community setting.

These services encompass community-based services designed to assist the individual in strengthening or regaining interpersonal skills; psycho-social therapy targeted toward rehabilitation; and development of environmental supports necessary to thrive in the community.

Psychosocial rehabilitative services are appropriate for individuals exhibiting psychiatric, behavioral or cognitive symptoms, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, pre-vocational and educational functioning.

Psychosocial rehabilitation services combine daily medication use, independent living and social skills training, support to clients and their families, housing, prevocational and transitional employment rehabilitation training, social support and network enhancement, structured activities to diminish tendencies towards isolation and withdrawal and teaching of the recipient and family about symptom management, medication and treatment options.

This service describes activities that are intended to restore an individual's skills and abilities essential for independent living. Activities include development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services.

These services are designed to assist the individual to compensate for or eliminate functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment focusing on maximum recovery and independence. It includes work readiness assessment, job development on behalf of the individual, job matching, on the job training, and job support.

SPECIFIC ADMISSION CRITERIA

1. There is reasonable expectation that the individual will be able to respond to intervention at this level of care and
2. There are symptoms of impairment in at least one life area
3. Supportive therapies may be medically recommended to prevent the need for more intensive level for some individuals.

SPECIFIC EXCLUSION CRITERIA

1. The individual is assessed as needing a more structured program than is offered at this level of care and:
   A. Such a program is available to the individual
   B. Such a program is assessable to the individual
2. The individual has medical impairments to a degree that renders treatment at this level of service ineffective
3. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
4. The individual or the parent /legal guardian if the individual is under 18, does not give voluntary consent for treatment, unless there is a court commitment

5. The individual is in need of more structure and supervision than is offered by this level of care

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual's needs can not be better met by either a higher or lesser level of care
3. Services are individualized and directly related to the treatment plan goals and the individual's long-term goals for residential, work/education and other life domains
4. Services delivered are supported by clinical and research data to have the expectation of improving the individual's symptoms
5. Referral is made as appropriate for psychiatric evaluation and medication management
6. Continued intervention at this level of care is necessary to alleviate identified problems
7. Continued intervention at this level of care is required to maintain the individual so that the risk of needing a higher level of service is reduced
8. Individual/caregiver is provided information and education regarding the individual's mental illness and the means to cope with this in the home environment

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for Psychosocial Rehabilitation services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for treatment is withdrawn
5. Level of functioning shows improvement
6. No reported Assaultive or destructive behavior
7. The individual demonstrates the ability to maintain stability
8. Maximum therapeutic progress has been achieved
9. Treatment goals and objectives have been met to a significant degree
10. The individual is not meeting treatment goals as outlined on the treatment plan, and there is no reasonable expectation of progress at this level of care
11. The individual/family refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record
12. The individual/family refuses to follow program rules and regulations to such a degree that continued treatment at this level of care is ineffective and/or unsafe

CLUBHOUSE: ADULT/ADOLESCENT

Clubhouse services are structured community-based group services that are provided in a group rehabilitation service setting.

These services encompass community-based services designed to assist the individual in strengthening or regaining interpersonal skills; psycho-social therapy targeted toward rehabilitation; and development of environmental supports necessary to thrive in the community.

Clubhouse services are appropriate for individuals exhibiting psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, pre-vocational and educational functioning.

A clubhouse is a place where people who have a mental illness come to rebuild their lives. The participants are called members, not patients and the focus is on their strengths not their illness. Work in the clubhouse, whether it is clerical, data input, meal preparation or reaching out to their fellow members, provides the core healing process. Structured, community-based Clubhouse group services include a range of social, educational, pre-vocational and transitional employment rehabilitation training in a group rehabilitation service setting utilizing behavioral, cognitive or supportive interventions to improve a recipient's potential for establishing and maintaining social relationships and obtaining occupational or educational achievements. Every opportunity provided is the result of the efforts of the members and staff, who work side by side, in a unique partnership.

A clubhouse group service is designed to strengthen and improve the individual's interpersonal skills, provide psychosocial therapy toward rehabilitation that emphasizes a holistic approach focusing on the recipient's strengths and abilities to promote recovery from mental illness. This service is primarily rehabilitative in nature, using a wellness model that offers a setting to restore independent living skills. These services are designed to assist the individual to eliminate the functional, interpersonal and environmental barriers created by their disabilities and to restore social skills for independent living and effective life management. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment focusing on maximum recovery and independence. Generally, Clubhouse membership is for life and the Clubhouse will provide an effective outreach system to members who are not attending, becoming isolated in the community or hospitalized.

Clubhouse services must be based upon the International Center for Clubhouse Development (ICCD) International Standards for Clubhouse Programs and certification of meeting ICCD Standards must be obtained within three years of member enrollment. The principles expressed in these Standards are at the heart of the clubhouse community's success in helping people with mental illness to stay out of hospitals while achieving social, financial and vocational goals. The Standards provide the basis for assessing clubhouse quality. Members and staff of ICCD-certified clubhouses from around the world review and update ICCD standards every 2 years. ICCD Standards can be viewed at http://www.iccd.org.

SPECIFIC ADMISSION CRITERIA

1. There is reasonable expectation that the individual will be able to respond to intervention at this level of care and
2. The individual is at least 16 years of age
3. Supportive therapies may be medically recommended to prevent the need for more intensive level for some individuals.

SPECIFIC EXCLUSION CRITERIA

1. The individual is assessed as needing a more structured program than is offered at this level of care and:
   A. Such a program is available to the individual
   B. Such a program is assessable to the individual
2. The individual's condition is such, or the individual is such a risk to self, or poses a current and significant threat to the general safety of the clubhouse community, that a more intensive level of care is needed
3. The individual is less than 16 years of age
4. The individual or the parent /legal guardian if the individual is under 18, does not give voluntary consent for treatment
5. The individual is in need of more structure and supervision than is offered by this level of care

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual's needs can not be better met by either a higher or lesser level of care
3. Services are individualized and directly related to the treatment plan goals and the individual's long-term goals for residential, work/education and other life domains
4. Referral is made as appropriate for psychiatric evaluation and medication management
5. Continued intervention at this level of care is necessary to alleviate identified problems
6. Continued intervention at this level of care is required to maintain the individual so that the risk of needing a higher level of service is reduced
7. Individual/caregiver is provided information and education regarding the individual's mental illness and the means to cope with this in the home environment

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for Clubhouse services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for treatment is withdrawn
5. Level of functioning shows improvement
6. The individual demonstrates the ability to maintain stability
7. Support systems are available that allow for a termination of services or for referral to a lower level of care
8. Maximum therapeutic progress has been achieved
9. Treatment goals and objectives have been met to a significant degree
10. The individual is not meeting treatment goals as outlined on the treatment plan, and there is no reasonable expectation of progress at this level of care
11. The individual/family refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record
12. The individual/family refuses to follow program rules and regulations to such a degree that continued treatment at this level of care is ineffective and/or unsafe

INTENSIVE CASE MANAGEMENT: ADULT

This level of care for case management is the most intensive and serves individuals with the most severe and disabling mental conditions. Services are frequent and intense with a focus on assisting the individual with attaining the skills and supports needed to gain independent living skills. Intensive case management services are provided primarily in the recipient's residence and include community-based interventions. The services shall be provided in the least restrictive setting with the goal of improving the client's level of functioning, and providing ample opportunities for rehabilitation, recovery, and self-sufficiency. Intensive targeted case management services shall be accessible 24 hours per day, 7 days per week.

This service is intended to provide intensive team case management to highly recidivistic adults who have a severe and persistent mental illness. The service is intended to help recipients remain in the community and avoid institutional care.

Intensive case management teams shall provide coordination and case management services for individuals admitted to inpatient facilities, state mental hospitals, and forensic or corrections facilities. The maximum average caseload size for a team with four or more case managers shall be 15 persons per each team case manager. The maximum average caseload size for a team with three case managers shall be seven persons per each team case manager.

Intensive Case Management services are available for adults who:

- Are awaiting admission or discharge to a long-term mental health institution or residential facility or are currently residing in a long-term mental health institution or residential facility
- Are experiencing long term or serious acute episodes of mental impairment and may require more intensive mental health treatment, requiring one or more admissions to acute psychiatric care
- Are requiring numerous services from different providers and requiring advocacy and coordination to implement or access services
- Would be unable to access or maintain consistent care within the service delivery system without Targeted Case Management services
- Do not possess the strengths, skills, or support system to allow them to access or coordinate services
- Are without the skills or knowledge necessary to access services

SPECIFIC ADMISSION CRITERIA

1. Evidence of mental illness
2. Documentation in the medical record clearly supports that:
   A. The individual meets the eligibility criteria outlined in Section 1; and
   B. The services are medically necessary for the treatment of the individual's mental health
   C. The individual displays disabling psychiatric symptoms or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, vocational, or educational functioning; and
   D. The services can be expected to retard deterioration, maintain, or improve the individual's condition and functional level; and
   E. The individual's condition and function level cannot be improved in a less restrictive level of care; and
   F. The individual is in need of linkage to community resources, advocacy, and coordination of services and lacks the strength, support system, knowledge and/or skills to perform these services on their own; and

3. There is a reasonable expectation that the individual can benefit from intensive case management services; and
4. Without assistance the individual is at risk for a more intensive level of care

SPECIFIC EXCLUSION CRITERIA

1. Services can safely and effectively be provided at a lower level of care
2. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
3. The individual does not give voluntary consent for treatment
4. The individual is in need of more structure and supervision than is offered by the intensive case management program

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual needs can not be better met by either a higher or less intensive level of care
3. Services are individualized and directly related to the service plan goals and the individual's long-term goals for residential, work and other life domains
4. Service planning is individualized with specific goals and objectives
5. Referral is made as appropriate for psychiatric evaluation and medication management
6. The individual continues to need intensive case management support in order to obtain and coordinate needed services

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for intensive case management services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for intensive case management services is withdrawn
5. Service plan goals and objectives have been met to significant degree
6. The individual demonstrates the skills and abilities necessary to effectively access and coordinate required services
7. The individual refuses to follow program rules and regulations to such a degree that continued intervention at this level of care is ineffective and/or unsafe

INTENSIVE CASE MANAGEMENT: CHILD

This level of care for case management is the most intensive and serves individuals with the most severe and disabling mental conditions. Services are frequent and intense with a focus on assisting the individual with attaining the skills and supports needed to gain independent living skills. Intensive case management services are provided primarily in the recipient's residence and include community-based interventions. The services shall be provided in the least restrictive setting with the goal of improving the client's level of functioning, and providing ample opportunities for rehabilitation, recovery, and self-sufficiency. Intensive targeted case management services shall be accessible 24 hours per day, 7 days per week.

Intensive case management teams shall provide coordination and case management services for individuals admitted to inpatient facilities, state mental hospitals, and forensic or corrections facilities, and for children involved with the Department of Children and Families, or the community-based care system. The maximum average caseload size for a team with four or more case managers shall be 15 persons per each team case manager. The maximum average caseload size for a team with three case managers shall be seven persons per each team case manager.

Case managers are also responsible for coordination and collaboration with the parents or guardians of children who receive mental health case management services. The case managers shall make reasonable efforts to assure that the parents or guardians of the children are included in the case management process. Integration of the parent's input and involvement with the case manager and other providers shall be reflected in clinical record documentation.

Intensive Case Management services are available for children who:

- Have a serious emotional disturbance defined as: a child with a diagnosed mental disorder; a level of functioning which requires two or more coordinated mental health services to be able to live in the community; and be at imminent risk of out of home mental treatment placement
- Are experiencing long term or serious acute episodes of mental impairment and may require more intensive mental health treatment requiring one or more admissions to acute psychiatric care
- Are requiring numerous services from different providers and requiring advocacy and coordination to implement or access services
- Would be unable to access or maintain consistent care within the service delivery system without case management services,
- Do not possess the strengths, skills, or support system to allow them to access or coordinate services (or their parent/caregiver does not possess such knowledge)
- Are without the skills or knowledge necessary to access services (or their parent/caregiver is without such knowledge)

SPECIFIC ADMISSION CRITERIA

1. Documentation in the medical record clearly supports that:
   A. The individual meets the eligibility criteria.
   B. The services are medically necessary for the treatment of the individual's mental health.
   C. The individual displays disabling psychiatric symptoms or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, vocational, or educational functioning; and

D. The services can be expected to retard deterioration, maintain, or improve the individual's condition and functional level; and
E. The individual's condition and function level cannot be improved in a less restrictive level of care; and
F. The individual/FAMILY is in need of linkage to community resources, advocacy, and coordination of services and lacks the strength, support system, knowledge and/or skills to perform these services on their own; and

6. There is a reasonable expectation that the individual can benefit from Intensive Case Management services; and
7. Without assistance the individual is at risk for a more intensive level of care.

SPECIFIC EXCLUSION CRITERIA

1. Services can safely and effectively be provided at a lower level of care
2. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
3. The individual's legal guardian/caregiver does not give voluntary consent for treatment
4. The individual is in need of more structure and supervision than is offered by the Intensive Case Management program

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual needs can not be better met by either a higher or less intensive level of care
3. Referral is made as appropriate for psychiatric evaluation and medication management
4. The individual continues to need Intensive Case Management support in order to obtain and coordinate needed services

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for Intensive Case Management services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for Intensive Case Management services are withdrawn by the legal guardian/caregiver
5. Service plan goals and objectives have been met to significant degree
6. Physical condition is such that individual is unable to participate in Intensive case management services
7. The individual or individual's legal guardian/caregiver demonstrates the skills and abilities necessary to effectively access and coordinate required services
8. The individual or individual's legal guardian/caregiver refuses to follow program rules and regulations to such a degree that continued intervention at this level of care is ineffective and/or unsafe

TARGETED CASE MANAGEMENT: ADULT

The purpose of Targeted Case Management is to ensure that members who are seriously and persistently mentally ill are able to access needed services and treatment in the least restrictive environment. The individual should remain in the community, if possible, so that he or she may function at their most independent level and especially to maintain continuity of care.

Mental Health Targeted Case Management services include working with the individual and the individual's natural support system to develop and promote a needs assessment-based service plan. The service plan reflects the services or supports needed to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used should identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the individual, family, and other natural support systems. Targeted case managers focus on overcoming barriers by collaborating and coordinating with other service providers and the individual to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of services provided. . The current state standard case load size is 40 priority clients in active status per case manager.

When targeted case management clients are hospitalized in an acute care setting, state mental hospital, or are incarcerated in a forensic or corrections facility, the case manager shall maintain contact with the individual and shall participate actively in the discharge planning processes and assist clients in corrections facilities with immediate access to care upon return to the community.

Targeted Case Management services are available for adults who:

- Are awaiting admission or discharge to a long-term mental health institution or residential facility or are currently residing in a long-term mental health institution or residential facility
- Are experiencing long term or serious acute episodes of mental impairment and may require more intensive mental health treatment, requiring one or more admissions to acute psychiatric care
- Are requiring numerous services from different providers and requiring advocacy and coordination to implement or access services
- Would be unable to access or maintain consistent care within the service delivery system without Targeted Case Management services
- Do not possess the strengths, skills, or support system to allow them to access or coordinate services
- Are without the skills or knowledge necessary to access services

SPECIFIC ADMISSION CRITERIA

1. Documentation in the medical record clearly supports that:
   A. The individual meets the eligibility criteria
   B. The services are medically necessary for the treatment of the individual's mental health
   C. The individual displays disabling psychiatric symptoms or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, vocational, or educational functioning and
   D. The services can be expected to retard deterioration, maintain, or improve the individual's condition and functional level and

E. The individual's condition and function level cannot be improved in a less restrictive level of care and
F. The individual is in need of linkage to community resources, advocacy, and coordination of services and lacks the strength, support system, knowledge and/or skills to perform these services on their own and

2. There is a reasonable expectation that the individual can benefit from Targeted Case Management services and
3. Without assistance the individual is at risk for a more intensive level of care

SPECIFIC EXCLUSION CRITERIA

1. Services can safely and effectively be provided at a lower level of care
2. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
3. The individual does not give voluntary consent for treatment
4. The individual is in need of more structure and supervision than is offered by the Targeted Case Management program

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual needs can not be better met by either a higher or less intensive level of care
3. Services are individualized and directly related to the service plan goals and the individual's long-term goals for residential, work and other life domains
4. Service planning is individualized with specific goals and objectives
5. Referral is made as appropriate for psychiatric evaluation and medication management
6. The individual continues to need Targeted Case Management support in order to obtain and coordinate needed services

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for Targeted Case Management services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for Targeted Case Management services are withdrawn
5. Service plan goals and objectives have been met to significant degree
6. The individual demonstrates the skills and abilities necessary to effectively access and coordinate required services
7. The individual refuses to follow program rules and regulations to such a degree that continued intervention at this level of care is ineffective and/or unsafe

TARGETED CASE MANAGEMENT: CHILD

The purpose of Targeted Case Management is to ensure that members who are seriously and persistently mentally ill are able to access needed services and treatment in the least restrictive environment. The individual should remain in the community, if possible, so that he or she may function at their most independent level and especially to maintain continuity of care.

Mental Health Targeted Case Management services include working with the child and the child's natural support system to develop and promote a needs assessment-based service plan. The service plan reflects the services or supports needed to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used should identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the client, family, and other natural support systems. Targeted case managers focus on overcoming barriers by collaborating and coordinating with other service providers and the child to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of services provided. The current state standard case load size is 20 priority clients in active status per case manager

When targeted case management children are hospitalized in an acute care setting, state mental hospital, or are incarcerated in a forensic or corrections facility, the case manager shall maintain contact with the individual/family and shall participate actively in the discharge planning processes and assist children in corrections facilities with immediate access to care upon return to the community.

Case managers are responsible for coordination and collaboration with the Department of Children and Families, or the community-based care system, for services provided to children who are in the care or custody of the state.

Case managers are also responsible for coordination and collaboration with the parents or guardians of children who receive mental health targeted case management services. The case manager shall make reasonable efforts to include the parents or guardians of the child in the case management process. Integration of the parent's input and involvement with the case manager and other providers shall be reflected in clinical record documentation.

Targeted Case Management services are available for children who:

- Have a serious emotional disturbance defined as: a child with a diagnosed mental disorder; a level of functioning which requires two or more coordinated mental health services to be able to live in the community; and be at imminent risk of out of home mental treatment placement
- Are experiencing long term or serious acute episodes of mental impairment and may require more intensive mental health treatment requiring one or more admissions to acute psychiatric care
- Are requiring numerous services from different providers and requiring advocacy and coordination to implement or access services
- Would be unable to access or maintain consistent care within the service delivery system without case management services,

- Do not possess the strengths, skills, or support system to allow them to access or coordinate services (or their parent/caregiver does not possess such knowledge)
- Are without the skills or knowledge necessary to access services (or their parent/caregiver is without such knowledge)

SPECIFIC ADMISSION CRITERIA

1. Documentation in the medical record clearly supports that:
   A. The individual meets the eligibility criteria and
   B. The services are medically necessary for the treatment of the individual's mental health
   C. The individual displays disabling psychiatric symptoms or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, vocational, or educational functioning and
   D. The services can be expected to retard deterioration, maintain or improve the individual's condition and functional level and
   E. The individual's condition and function level cannot be improved in a less restrictive level of care and
   F. The individual is in need of linkage to community resources, advocacy, and coordination of services and lacks the strength, support system, knowledge and/or skills to perform these services on their own AND
2. There is a reasonable expectation that the individual can benefit from case management services AND
3. Without assistance the individual is at risk for a more intensive level of care

SPECIFIC EXCLUSION CRITERIA

1. Services can safely and effectively be provided at a lower level of care
2. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
3. The individual's legal guardian/caregiver does not give voluntary consent for treatment
4. The individual is in need of more structure and supervision than is offered by the case management program

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual needs can not be better met by either a higher or less intensive level of care
3. Services are individualized and directly related to the service plan goals and the individual's long-term goals for residential, work and other life domains
4. Service planning is individualized with specific goals and objectives
5. Referral is made as appropriate for psychiatric evaluation and medication management
6. The individual continues to need case management support in order to obtain and coordinate needed services

DISCHARGE CRITERIA

1. Admission criteria for case management services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for case management services is withdrawn by the legal guardian/caregiver
5. Service plan goals and objectives have been met to a significant degree
6. The individual or individual's legal guardian/caregiver demonstrates the skills and abilities necessary to effectively access and coordinate required services

7. The individual or individual's legal guardian/caregiver refuses to follow program rules and regulations to such a degree that continued intervention at this level of care is ineffective and/or unsafe.

PSYCHOLOGICAL TESTING: ADULT/CHILD

Psychological testing involves the assessment, evaluation, and diagnosis of mental status through use of standardized testing methodologies.

Psychological testing must be provided by an individual practitioner within the scope of professional licensure, training, protocols, and competence and in accordance with applicable statutes.

A written report of evaluation and testing results must be done by the individual rendering service and must be included in the medical record for all evaluation and testing services listed in the evaluation and testing section.

SPECIFIC ADMISSION CRITERIA

Recipients are eligible to receive psychological testing only under the following circumstances:

1. At the onset of illness or suspected illness or when the recipient first presents for treatment.
2. Testing may be repeated if an extended hiatus in treatment or a marked change in status occurs, or if the recipient is being considered for admission or readmission to a psychiatric inpatient setting.
3. When there is difficulty determining a diagnosis or where there are differential diagnostic impressions; or
4. To gather additional information to evaluate or redirect treatment efforts.

SPECIFIC EXCLUSION CRITERIA

1. The client received psychological testing within the last year, and there is no strong evidence that the client's condition or functioning is significantly different.
2. Testing primarily
   A. for educational purposes
   B. for legal purposes
   C. for cognitive rehabilitation, or vocational guidance, or
   D. primarily to guide the titration of medication
3. Testing requested within 30 days of active substance abuse.
4. Testing that appears more routine than medically necessary.
5. Interpretation and supervision of neuropsychological testing is done by someone other than a licensed psychologist with a specialty in neuropsychological.
6. Testing proposed has no standardized norms or documented validity.
7. No evidence that symptoms are result of mental illness
8. The primary presenting problem is economic, social, or medical without concurrent acute Symptomology of mental illness
9. The following conditions are excluded except where there is a coexisting psychiatric diagnosis with symptoms that meet admission criteria, and it is the psychiatric condition that is the focus of the intervention:
   A. Previously diagnosed mental retardation
   B. Autism
   C. Pervasive Developmental Delay
   D. Non-emotional or non-behavioral developmental delays
   E. Delirium, Dementia, Amnestic and Other Cognitive Disorders
   F. Primary Substance Abuse/Dependence Disorders
   G. Mental Disorders Due to a General Medical Condition
10. The individual/legal guardian does not give voluntary consent for Psychological Testing

11. In some instances, testing ordered by a medical provider (e.g., PCP, pediatrician, neurologist)

SPECIFIC CONTINUED STAY CRITERIA
Continued stay criteria not applicable

SPECIFIC DISCHARGE CRITERIA
Discharge criteria not applicable

ELECTROCONVULSIVE THERAPY: ADULT/CHILD

The decision to use Electroconvulsive Therapy (ECT), while in continuous use for more than 60 years and established as a highly effective treatment modality by supporting evidence, derives from a risk/benefit analysis for the specific patient. Consideration of the diagnosis of the patient and the severity of the presenting illness, the patient's treatment history, the anticipated speed of action and the efficacy of ECT, the medical risks and anticipated adverse side effects should be measured against the likely speed of action, efficacy, and medical risks of alternative treatments.

ECT is indicated when attempts at more conservative treatments have failed as an intervention for Major Depression, Acute Mania, and Schizophrenia and Related Psychotic Disorders. ECT should be considered when a rapid response is needed, as in a case where patients are exhibiting severe medical risk due to the inability to care for themselves or are at risk of self harm or harm to others.

ECT is most commonly considered for patients who have not clinically responded to treatment courses of adequate length of multiple antidepressants at therapeutic doses, whether due to intolerance of side effects or continued deterioration in the psychiatric condition. In general, a failure of one class of antidepressants should be followed by trials of antidepressants from different chemical families.

The best response to ECT is noted when the duration of the illness from the initial onset is short, when psychotic symptoms in the present episode have an abrupt or recent onset, in the presence of catatonia, or when there has been a favorable response to ECT in the past.

Major Diagnoses Indicating Use of ECT:

- Major Depression
- Bipolar I Disorder
- Schizophrenia and other Functional Psychosis
- Psychotic schizophrenic exacerbation in the following situations
    - Catatonia (295.x2)
    - When affective symptomology is present
    - When there is a history of favorable response to ECT
- Schizoaffective Disorder with significant affective symptoms

SPECIFIC CRITERIA

ECT may be used prior to a trial of psychotropic medication in the following situations (but not limited to):

- Need for rapid, definitive response on either medical or psychiatric grounds
- Risks of other treatments outweigh the risks of ECT
- Adverse effects which are unavoidable, and which are deemed less likely and/or less severe with ECT

Indications for use of ECT:

- History of poor drug response and/or good ECT response for previous episodes of the illness
- After an initial trial of an alternate treatment, referral for ECT should be based on at least one of the following:
    - Treatment failure

    - Deterioration of the patient's condition such that there is a need for rapid, definitive response on either medical or psychiatric grounds
- The patient must be evaluated by a psychiatrist privileged to administer ECT who is not currently involved in the case and who concurs with the attending physician's decision to administer ECT with documentation of findings in the clinical record
- The patient must have a complete medical evaluation to define risk factors including anesthesia evaluation (medical history, physical examination, vital signs, laboratory tests at the discretion of the physician examining the patient, and electrocardiogram)
- The patient or legal guardian must give informed consent after a full description of the ECT procedure is explained to include:
    - When, where, and by whom the treatments will be given
    - A range of the number of treatment sessions likely
    - An overview of the ECT treatment itself to include any restrictions on patient behavior that are necessary prior to, during or following ECT
    - Risks of ECT as well as anesthesia risks, benefits, reasonable treatment alternatives, and expected outcome of treatment, especially that benefits associated with ECT may be temporary
- The patient or legal guardian should understand that consent is voluntary and may be withdrawn at any time before or during the course of treatment

Level of Care
Initial treatment with ECT is generally started with the patient in an inpatient hospital setting. However, the patient may transition to an outpatient setting as the course of ECT progresses and the patient's condition improves. For consideration for outpatient ECT, there must be an identified support system available to assist in compliance with treatment protocols and provide transportation. See "Clinical Criteria: Adult Inpatient Hospitalization" and "Clinical Criteria: Child/Adolescent Inpatient Hospitalization" for admission, exclusion, continued stay, and discharge criteria.

Contraindications/Risk Factors
There are three strong caveats in the use of ECT: Changes in the autonomic nervous system that cause a transient rise in blood pressure, increased cardiac workload, and increase in heart rate could pose a substantial risk to the individual with recent myocardial infarction, congestive heart failure, valvular cardiac disease, or other severe heart disease. With the transient increase in intracranial pressure during ECT, patients with space occupying lesions or evidence of blood vessel fragility such as aneurysms or vascular malformation are at increased risk. With the transient increase in the permeability of the blood brain barrier during ECT, doses of medications that cross the blood brain barrier may need adjustment.

Medical conditions associated with substantial risk include:
- Recent cerebral infarction
- Pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia
- Anesthetic risk rated as ASA level 4 or 5
- Retinal detachment
- Pheochromocytoma
- Recent myocardial infarction
- Intracranial space occupying lesion (tumor, aneurysm, etc.)

Special Populations

- Concurrent Medical Illness
    - The anticipated benefits for the patient should be weighed against the patient's medical status
    - The pre-ECT medical evaluation should include pertinent laboratory tests and specialist consultation when indicated
    - Informed consent should include the existence and implications of medical conditions associated with significant increased risk
    - Modification of the ECT procedure should be considered when indicated to lower potential morbidity and/or augment efficiency. (For example, changing the ECT technique, altering pharmacological routines, utilizing additional medical specialists or monitoring procedures)
- Elderly
    - Clinical experience suggests that among the elderly, ECT may have less risk of complications than some forms of pharmacotherapy
    - Medication dosages may need modification based on the physiological changes associated with aging
    - As the seizure threshold generally increases with age, ECT stimulus intensity may need adjustment
    - While ECT may be used regardless of age, ECT-induced cognitive dysfunction may be greater in the elderly adult, and the ECT technique should be modified to minimize adverse cognitive effects
    - Alter the electrodes from bilateral to unilateral
    - Decrease intensity of electrical stimulation
    - Increase time interval between treatments
    - Alter the medication dosage
    - Terminate treatment, if necessary
- Pregnancy
    - ECT may be used in all three trimesters of pregnancy, and the risk of anesthetic agents to the fetus are likely to be less than those of pharmacologic alternatives
    - Informed consent should include the potential for teratogenic risks in the first eight weeks of gestation and the potential risks of neonatal toxicities from anesthesia
    - When the gestational age is greater than 10 weeks, noninvasive monitoring of the fetal heart rate should be done before and after each ECT treatment
    - Obstetric consultation should be obtained prior to ECT and, if the pregnancy is near term or high risk, the presence of an obstetrician and/or additional monitoring may be indicated at the time of ECT treatment as there is the chance of precipitating labor in the third trimester
    - Resources for managing obstetrical emergencies should be readily available
- Children and Adolescents
    - ECT is a psychiatric intervention rarely indicated in the treatment of children and adolescents and should only be considered as an option for a seriously ill child or adolescent who has failed to respond to other treatment efforts
    - There is very limited data or clinical experience in the use of ECT in preadolescent children, and its use in this population should be carefully considered
    - For a child/adolescent who is age 17 or under, two psychiatrists not otherwise involved with the case and at least one and preferably both experienced in the treatment of children, including somatic therapies, should concur that the treatment would be beneficial after review of the record and interviews with the child/adolescent and parent/guardian, as well as discussion of the case with the attending physician

    - ECT should be discussed in detail with both parents/legal guardian and the patient, and informed consent obtained
    - Only qualified personnel experienced in treating children and adolescents should administer anesthesia

Adverse Reactions
- Cognitive dysfunction
    - Orientation and memory function should be assessed before and after each ECT treatment
    - Based on the severity of the cognitive side effects, the physician administering the ECT should consider alteration of the ECT technique and/or the patient's pharmacological regime
- Cardiovascular complications
- Prolonged seizures
- Prolonged apnea
- Systemic side effects (most common)
- Headache
- Nausea
- Treatment emergent mania
- Adverse subjective reactions by patients or their families

Treatment Course
- Frequency and number of treatments
    - ECT is most commonly performed three times per week every other day for 6-12 treatments
    - The total number of treatments administered should be a reflection of the degree of clinical improvement of the patient and the severity of the cognitive adverse side effects
    - The evaluation of the response should focus on the target symptoms, with an assessment made between each treatment
- ECT should be terminated as soon as it is clear that maximum response has been reached or if there is no significant clinical improvement after 10-12 treatments
- There is no evidence that repeated courses of ECT lead to permanent structural damage, or that a maximum limit on lifetime number of treatments with ECT is appropriate

Use of psychotropic medical agents during ECT course
- Medications that increase morbidity or decrease the efficacy of ECT should be discontinued or decreased prior to ECT
    - Benzodiazepines
    - Most other sedative hypnotics
    - Anticonvulsants
    - Lidocaine and its analogues
    - Reserpine
    - Lithium
    - Theophylline
- It is advisable to discontinue psychotropic agents prior to ECT, although this should not delay treatment
- Low to moderate doses of neuroleptics with ECT may sometimes be helpful early in the treatment course for patients with psychosis
- For monoamine oxidase inhibitors, a drug-free period is not necessary prior to ECT

- Medications to be administered before ECT on treatment days should be clearly specified

Post ECT course
- Therapy should be continued for virtually all patients and should typically include psychotropic medications and/or maintenance ECT
- Medication should be determined by the underlying illness, side effects, and the patient's medication history
- Maintenance ECT should be administered at the minimum frequency to maintain sustained remission, generally every one to four weeks, and the need for ECT should be reassessed every three months

References

- American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders
- Child and Adolescent Psychiatry Practice Parameters
- Diagnostic and Statistical Manual of Mental Disorders

PSYCHOSOCIAL REHABILITATION MAINTAINANCE: ADULT

Psychosocial Rehabilitation Maintenance is a service within the Community Rehabilitation Services (CRS) program located at Southeastern Vocational Services (SVS). This service provides the following:

- Social Skills training
- Employability Skills training
- Work opportunity for individuals with disabilities in a structured and supervised environment.
- Vocational Counseling
- Case Management
- Job coaching

This service is designed for those individuals who are not yet ready for competitive employment due to a mental illness, but who have reached maximum benefit from Psychosocial Rehabilitation Services. Clients who have not had Psychosocial Rehabilitation Services but are assessed as appropriate for Psychosocial Rehabilitation Maintenance Services are also appropriate for this service. Rehabilitation Instructors are on-site and coach the individuals as they work to develop skills that will increase their readiness for competitive employment. This is done in a sheltered and supportive work environment.

The service provision is tailored to the needs of the individual as outlined on the Individualized Treatment Plan. The Individualized Treatment Plan is formulated with the individual and is updated as needed, but at least every six months.

Service Providers: Rehabilitation Instructors, who are supervised by a bachelor's level practitioner

Required Documentation:

- Documentation of assessment to determine that the individual is appropriate for Psychosocial Rehabilitation Maintenance
- Individualized Treatment Plan
- Treatment Plan Reviews
- Monthly Progress Notes that reflect how the services are linked to the goals and objectives of the individual's Treatment Plan; and describes the individual's progress relative to the Treatment Plan.

SPECIFIC ADMISSION CRITERIA

1. There is reasonable expectation that the individual will be able to respond to intervention at this level of care and
2. There is evidence that the symptoms related to mental illness have impacted the individual's ability to work and
3. The person is at least 18 years of age

SPECIFIC EXCLUSION CRITERIA

1. The individual is assessed as needing treatment services not available in this service
2. The individual has medical impairments to a degree that renders services at this level of service ineffective
3. The individual's condition is such, or the individual is such a risk to self or others, that a more intensive level of care is needed
4. The individual is under 18

5. The individual does not give consent for transitional employment services
6. The individual is in need of more structure and supervision than is offered by this level of care

SPECIFIC CONTINUED STAY CRITERIA

The following criteria must all be met in order for treatment to continue at this level of care:

1. Admission criteria continues to be met
2. The individual's needs can not be better met by either a higher or lesser level of care
3. Services are individualized and directly related to the treatment plan goals and the individual's long-term goals for employment
4. Services delivered are supported by clinical and research data to have the expectation of improving the individual's ability to function independently in the work force
5. Need for continued intervention at this level of service is required to address lack of progress toward treatment goals or although progress is evident, specified goals of treatment have not yet been met
6. Referral is made as appropriate for psychiatric evaluation and medication management
7. Continued intervention at this level of care is necessary to alleviate identified problems
8. Continued intervention at this level of care is required to maintain the individual so that the risk of needing a higher level of service is reduced
9. Individual/caregiver, and employer if appropriate, is provided information and education regarding the individual's mental illness and the means to cope with this in the home or work environment

SPECIFIC DISCHARGE CRITERIA

1. Admission criteria for transitional employment services no longer met
2. Admission criteria for a lower level of care are met and is available/accessible
3. Admission criteria for a more acute level of care are met
4. Consent for treatment is withdrawn
5. Level of functioning shows improvement to such a degree that this service is no longer needed
6. The individual demonstrates the ability to maintain stability and to work independently
7. Maximum progress has been achieved
8. Treatment goals and objectives have been met to a significant degree
9. The individual is not meeting treatment goals as outlined on the treatment plan, and there is no reasonable expectation of progress at this level of care
10. The individual/family refuses to participate in treatment to such a degree that that continued treatment at this level of care is ineffective and/or unsafe. Documentation of attempts to address this issue is found in the medical record

SPECIALIZED THERAPEUTIC SERVICES

Specialized therapeutic services include comprehensive behavioral health assessments, specialized therapeutic foster care, and therapeutic group home services provided to recipients under the age of 21 years with mental health, substance use, and co-occurring mental health and substance use disorders. The intent of specialized therapeutic services is the maximum reduction of the recipient's disability and restoration to the best possible functional level. Services must be diagnostically relevant and medically necessary. Specialized therapeutic foster care and therapeutic group home services must be included in an individualized treatment plan that has been approved by a treating practitioner. Services are treatment events that correspond with Medicaid procedure codes. Services are not the same as interventions. Unless otherwise specified, the date(s) of service on each claim must correspond to the date(s) the service was rendered.

Specialized Therapeutic Foster Care

- Specialized therapeutic foster care services are intensive treatment services provided to recipients under the age of 21 years with emotional disturbances who reside in a state licensed foster home. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention.
- The goal of specialized therapeutic foster care is to enable a recipient to manage and to work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting.
- Specialized therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological, and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician, and a psychiatrist. A specialized therapeutic foster parent must be available 24 hours per day to respond to crises or to provide special therapeutic interventions.
- There are two levels of specialized therapeutic foster care, which are differentiated by the supervision and training of the foster parents and intensity of programming required. Specialized therapeutic foster care levels are intended to support, promote competency, and enhance participation in normal, age-appropriate activities of recipients who present moderate to serious emotional or behavior management problems. Programming and interventions are tailored to the age and diagnosis of the recipients.
- Specialized therapeutic foster care services are offered at Level I or Level II, with crisis intervention available at both levels.

SPECIFIC ADMISSION CRITERIA

Level I specialized therapeutic foster care is for recipients with a history of abuse or neglect, or delinquent behavior, and who have an emotional disturbance or serious emotional disturbance. The recipient must qualify for foster care and must meet at least one of the following criteria:

- Requires admission to a psychiatric hospital, a crisis stabilization unit, or a residential treatment center without specialized therapeutic foster care.
- Within the last two years, been admitted to one of these treatment settings.

A recipient requiring **Level II specialized therapeutic foster** care must meet the following criteria:

- Meet the criteria of Level I specialized therapeutic foster care.
- Be exhibiting more severe maladaptive behaviors such as:
    - Destruction of property

    - Physical aggression toward people or animals
    - Self-inflicted injuries
    - Suicidal ideations or gestures
    - An inability to perform activities of daily and community living due to psychiatric symptoms
- The recipient must require the availability of highly trained specialized therapeutic foster parents as evidenced by at least one of the behaviors or deficits listed above.

Specialized therapeutic foster care services may be used for a maximum of 30 days for **crisis intervention** for a recipient for whom services must occur immediately in order to stabilize a behavioral, emotional, or psychiatric crisis. Any exception to this length of stay must be approved in writing by the multidisciplinary team.

SPECIFIC EXCLUSION CRITERIA

1. Cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.

SPECIFIC CONTINUED STAY CRITERIA

1. Documented need for the service is contained in the individual's clinical record.

SPECIFIC DISCHARGE CRITERIA

1. The individual no longer is in need of this service.

Comprehensive Assessments

A comprehensive behavioral health assessment must be initiated within 10 working days of crisis intervention services for any recipient who has not had a comprehensive behavioral health assessment in the past year.

SPECIFIC ADMISSION CRITERIA

To receive a comprehensive behavioral health assessment, a recipient must be under the age of 21 years and meet all of the following criteria:

- Be a victim of abuse or neglect
- Have been determined by the Department of Children and Families (DCF) or their designee to require out-of-home care or be placed in shelter status

Or the recipient must meet all of the following criteria:

- Have committed acts of juvenile delinquency
- Be suffering from an emotional disturbance or a serious emotional disturbance
- Be at risk for placement in a residential setting

SPECIFIC EXCLUSION CRITERIA

1. Cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.

SPECIFIC CONTINUED STAY CRITERIA

Continued stay criteria not applicable

SPECIFIC DISCHARGE CRITERIA

Discharge criteria not applicable

Therapeutic Group Care Services

- Therapeutic group care services are community-based, psychiatric residential treatment services designed for recipients under the age of 21 years with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 recipients under the age of 21 years.
- Therapeutic group care services are intended to support, promote, and enhance competency and participation in normal age-appropriate activities of recipients who present moderate to severe psychiatric, emotional, or behavior management problems related to a psychiatric diagnosis. Programming and interventions are highly individualized and tailored to the age and diagnosis of the recipient. Therapeutic group care is intended to provide a high degree of structure, support, supervision, and clinical intervention in a home-like setting.
- Therapeutic group care services are a component within Florida Medicaid's behavioral health system of care for recipients under the age of 21 years. They are appropriate for recipients under the age of 21 years who are ready to transition from a more restrictive residential treatment program or for those who require more intensive community-based treatment to avoid placement in a more restrictive residential treatment setting.
- The recipient's primary diagnosis and level of functioning are the reasons for treatment and the focus of the interventions and services provided. Generally, these services include psychiatric and therapy services, therapeutic supervision, and the teaching of problem-solving skills, behavior strategies, normalization activities, and other treatment modalities, as authorized in the treatment plan.

SPECIFIC ADMISSION CRITERIA

The multidisciplinary team must confirm that the recipient is appropriate for therapeutic group care placement by a licensed clinical psychologist, per section 490, F.S., or a board certified psychiatrist in compliance with section 394.4781 or 39.407, F.S., and has an emotional disturbance or serious emotional disturbance.

SPECIFIC EXCLUSION CRITERIA

1. Cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.

SPECIFIC CONTINUED STAY CRITERIA

1. Documented need for the service is contained in the individual's clinical record.

SPECIFIC DISCHARGE CRITERIA

1. The individual no longer is in need of this service.