BEACON HEALTH STRATEGIES, LLC. / NEW YORK LEVEL OF CARE CRITERIA

LEVEL OF CARE CRITERIA

Beacon's Level of Care (LOC) criteria were developed from the comparison of national, scientific and evidence based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). Beacon's LOC criteria, are reviewed and updated, at least annually, and as needed when new treatment applications and technologies are adopted as generally accepted medical practice.

Members must meet medical necessity criteria for a particular LOC of care. Medically necessary services are those which are:

A. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM-,) that threatens life, causes pain or suffering, or results in illness or infirmity.
B. Expected to improve an individual's condition or level of functioning.
C. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
D. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
E. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
F. Not primarily intended for the convenience of the recipient, caretaker, or provider.
G. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
H. Not a substitute for non-treatment services addressing environmental factors.

Beacon uses its LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. Beacon's LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system and social supports are taken into consideration.

In addition to meeting Level of Care Criteria; services must be included in the member's benefit to be considered for coverage.

SECTION I: INPATIENT BEHAVIORAL HEALTH

Overview

This chapter contains information on LOC criteria and service descriptions for inpatient behavioral health (BH) treatment including:

A. NMNC 1.101.0 Inpatient Psychiatric Services

Beacon's inpatient service rates are all inclusive with the **single exception** of electro-convulsive therapy (ECT). Routine medical care is also included in the per diem rate for inpatient treatment. **Any medical care above and beyond routine must be reported to Beacon for coordination of benefits with the health plan.**

A. NMNC 1.101.0 Inpatient Psychiatric Services

Acute Inpatient Psychiatric Services are the most intensive level of psychiatric treatment used to stabilize individuals with an acute, worsening, destabilizing, or sudden onset psychiatric condition with a short and severe duration. A structured treatment milieu and 24-hour medical and skilled nursing care, daily medical evaluation and management, (including a documented daily visit with an attending licensed prescribing provider),and structured milieu treatment are required for inpatient treatment. Treatment may include physical and mechanical restraints, isolation, and locked units.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Must have all criteria #1-4 and either 5 or 6, criteria #7 and #8 as applicable; for Eating Disorders #9-12, 1 must also be met: 1) Symptoms consistent with a DSM or corresponding ICD diagnosis 2) Member's psychiatric condition requires 24-hour medical/psychiatric and nursing services and of such intensity that needed services can only be provided by an acute psychiatric hospital care. 3) Inpatient psychiatric services are expected to significantly improve the member's psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical/psychiatric and nursing services will no longer be needed. 4) Symptoms do not result from a medical condition that would be more appropriately treated on a medical/surgical unit. 5) One of the following must also be present: a) Danger to self: i) A serious suicide attempt by degree of lethality and intentionality, suicidal ideation with plan and means available and/or history of prior serious suicide attempt; ii) Suicidal ideation accompanied by severely depressed mood, significant losses, and/or continued intent to harm	**Criteria #1 - 10 must be met; For Eating Disorders, criterion #11 or 12 must be met:** 1) Member continues to meet admission criteria; 2) Another less restrictive Level of Care would not be adequate to administer care. 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely require rapid re-hospitalization; 4) Treatment is still necessary to reduce symptoms and improve functioning so that the member may be treated in a less restrictive Level of Care. 5) There is evidence of progress towards resolution of the symptoms that are causing a barrier to	**Any one of the following: Criteria #1, 2, 3, or 4 ; criteria # 5 - 7 are recommended, but optional. For Eating Disorders, criteria #8 - 10 must be met:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment *and* member does not meet criteria for involuntary or mandated treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment

Admission Criteria	Continued Stay Criteria	Discharge Criteria
self; iii) Command hallucinations or persecutory delusions directing self-harm; iv) Loss of impulse control resulting in life threatening behavior or danger to self; v) Significant weight loss within the past three months; vi) Self-mutilation that could lead to permanent disability; b) Danger to others: i) Homicidal ideation and/or indication of actual or potential danger to others; ii) Command hallucinations or persecutory delusions directing harm or potential violence to others; iii) Indication of danger to property evidenced by credible threats of destructive acts iv) Documented or recent history of violent, dangerous, and destructive acts 6) Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning; 7) Evidence of severe disorders of cognition, memory, or judgment are not associated with a primary diagnosis of dementia or other cognitive disorder 8) Severe comorbid substance use disorder is present and must be controlled (e.g. abstinence necessary) to achieve stabilization of primary psychiatric disorder ***For Eating Disorder** 11) DSM or corresponding ICD diagnosis and symptoms consistent with a primary diagnosis of Eating Disorder 12) Member has at least one of the following: a) Psychiatric, behavioral, and eating disorder symptoms that are expected to respond to treatment in an Acute Level of Care b) Symptomatology that is not responsive to treatment in a less intensive Level of Care. c) An adolescent with newly diagnosed anorexia; 13) Member requires 24 hour monitoring, which includes: before, after,	treatment continuing in a less restrictive Level of Care; 6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. Treatment plan has been updated to address non-adherence. 7) The member is actively participating in plan of care and treatment to the extent possible consistent with his/her condition 8) Family/guardian/caregiver is participating in treatment where appropriate. 9) There is documentation of coordination of treatment with state or other community agencies, if involved. 10) Coordination of care and active discharge planning are ongoing, beginning at admission, with goal of transitioning the member to a less intensive Level of Care. ***For Eating Disorders**: 11) Member has had no appreciable weight gain (<2lbs/wk.) 12) Ongoing medical or refeeding complications.	plan and goals have been met. 6) Member's support system is aware and in agreement with the aftercare treatment plan. 7) Member's physical condition necessitates transfer to a medical facility. ***For Eating Disorders:** 8) Member has reached at least 85% ideal body weight and has gained enough weight to achieve medical stability (e. g., vital signs, electrolytes, and electrocardiogram are stable). 9) No re-feeding is necessary 10) All other psychiatric disorders are stable

Admission Criteria	Continued Stay Criteria	Discharge Criteria
and during meals; evening to monitor behaviors (i.e. Restricting, binging/purging, over-exercising, use of laxatives or diuretics); 14) Member exhibits physiological instability requiring 24 hour monitoring for at least one of the following: a) Rapid, life-threatening and volitional weight loss not related to a medical illness: generally <85% of IBW (or BMI of 15 or less. b) Electrolyte imbalance (i.e. Potassium <3) c) Physiological liability (i.e. Significant postural hypotension, bradycardia, CHF, cardiac arrhythmia); d) Change in mental status; e) Body temperature below 96.8 degrees; f) Severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement; g) Acute gastrointestinal dysfunction (i.e. Esophageal tear secondary to vomiting, mega colon or colonic damage, self-administered enemas) h) Heart rate is less than 40 beats per minute or less than 50 beats per minute for child. **Exclusions** ***Any*** *of the following criteria is sufficient for exclusion from this level of care:* 1) The individual can be safely maintained and effectively treated at a less intensive level of care. 2) Symptoms result from a medical condition which warrants a medical/surgical setting for treatment. 3) The individual exhibits serious and persistent mental illness **and** is not in an acute exacerbation of the illness. 4) The primary problem is social, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration		

Inpatient Substance Use Disorder Services - Medically Managed (Level IV Detoxification) - See ASAM Level 4 Criteria. For Medicaid, FIDA and Dually Eligible members, please refer to the LOCADTR Criteria.

Acute Substance Use Disorders Treatment – Medically Monitored (Level III Detoxification) - See ASAM Level 4 Criteria or ASAM level 3.7 Criteria for Hudson. For Medicaid, FIDA and Dually Eligible members, please refer to the LOCADTR Criteria.

Inpatient Acute Substance Disorder Rehabilitation (IP Rehab)- See ASAM Level 3.5 Criteria. For Medicaid, FIDA and Dually Eligible members, please refer to the LOCADTR Criteria.

SECTION II: DIVERSIONARY SERVICES

Overview

Diversionary services are those mental health and substance use treatment services that are provided as clinically appropriate alternatives to behavioral health inpatient services, or to support a member in returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.

This chapter contains service descriptions and level of care criteria for the following non-24-hour, diversionary services specifically designed to provide a continuum between inpatient and outpatient levels of care, including:

A. NMNC 3.301.0 Partial Hospitalization Program
B. NMNC 3.302.0 Intensive Outpatient Treatment For SA LOC See ASAM Criteria Level 2.1*
***For Medicaid, FIDA and Dually Eligible members, please refer to the LOCADTR Criteria.**
C. Day Treatment
D. NMNC 3.303.0 Day Treatment
E. Personalized Recovery Orientated Services (PROS)
F. Psychosocial Rehab (PSR)
G. Intensive Psychiatric Rehabilitation Treatment (IPRT)
H. Community Psychiatric Support and Treatment (CPST)
I. Assertive Community Treatment (ACT)

A. NMNC 3.301.0 Partial Hospitalization Program

Partial hospital programs (PHP) are short-term day programs consisting of intensive, acute, active treatment in a therapeutic milieu equivalent to the intensity of services provided in an inpatient setting. These programs must be available at least 5 days per week, though may also be available 7 days per week. The short-term nature of an acute PHP makes it inappropriate for long-term day treatment. A PHP requires psychiatric oversite with at least weekly medication management as well as highly structured treatment. The treatment declines in intensity and frequency as a member establishes community supports and resumes normal daily activities. A partial hospitalization program may be provided in either a hospital-based or community based location. Members at this level of care are often experiencing symptoms of such intensity that they are unable to be safely treated in a less intensive setting, and would otherwise require admission to an inpatient level of care. Children and adolescents participating in a partial hospital program must have a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on family, community supports, and school, the PHP consults with the caretakers and the child's programs as needed to implement behavior plans, or participate in the monitoring or administration of medications.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1 - 8 must be met; For Eating Disorders, criterion #9 – 10 must also be met: 1) Symptoms consistent with a DSM or corresponding ICD diagnosis; 2) The member manifests a significant or profound impairment in 3-daily functioning due to psychiatric illness. 3) Member has adequate behavioral control and is assessed not to be an immediate danger to self or others requiring 24-hour containment or medical supervision. 4) Member has a community-based network of support and/or parents/caretakers who are able to ensure member's safety outside the treatment hours. 5) Member requires access to a structured treatment program with an on-site multidisciplinary team, including routine psychiatric interventions for medication management. 6) Member can reliably attend and actively participate in all phases of the treatment program necessary to stabilize their condition. 7) The severity of the presenting symptoms is not able to be treated safely or adequately in a less intensive level of care. 8) Member has adequate motivation to recover in the structure of an ambulatory treatment program. **For Eating Disorders:** 9) Member requires admission for Eating Disorder Treatment and requires at least one of the following:	**Criteria # 1 - 7 must be met; For Eating Disorders, criterion # 8 and 9 must also be met:** 1) Member continues to meet admission criteria; 2) Another less intensive level of care would not be adequate to administer care. 3) Treatment is still necessary to reduce symptoms and increase functioning so the member may be treated in a less intensive level of care. 4) Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6) Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway.	**Any one of the following: Criteria 1, 2, 3, or 4; criteria # 5 and 6 are recommended, but optional; For Eating Disorders, criterion # 7 is also appropriate:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment. 3) Member does not appear to be participating in treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support systems are in agreement with the aftercare treatment plan. **For Eating Disorders**: 7) Member has been compliant with the Eating Disorder related protocols, medical status is stable and appropriate, and the member can now be managed in

Admission Criteria	Continued Stay Criteria	Discharge Criteria
a. Weight stabilization: generally >85% of IBW (or BMI of 16 or more) with no significant co-existing medical conditions (see IP #14) b. Continued monitoring of corresponding medical symptoms; c. Reduction in compulsive exercising or other repetitive eating disordered behaviors that negatively impacts daily functioning. 10) Any monitoring of member's condition when away from partial hospital program can be provided by family, caregivers, or other available resources **Exclusions** ***Any*** *of the following criteria are sufficient for exclusion from this level of care*: 1) The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required. 2) The individual does not voluntarily consent to admission or treatment or does not meet criteria for involuntary admission to this level of care. 3) The individual has medical conditions or impairments that would prevent beneficial utilization of services 4) The individual exhibits a serious and persistent mental illness consistent throughout time **and** is not in an acute exacerbation of the mental illness; 5) The individual requires a level of structure and supervision beyond the scope of the program (e.g., considered a high risk for non-compliant behavior and/or elopement). 6) The individual can be safely maintained and effectively treated at a less intensive level of care.	7) Coordination of care and active discharge planning are ongoing, with goal of transitioning member to a less intensive Level of Care. **For Eating Disorders:** 8) Member has had no appreciable stabilization of weight since admission; 9) Other eating disorder behaviors persist and continue to put the member's medical status in jeopardy.	a less intensive level of care.

B. NMNC 3.302.0 Intensive Outpatient Treatment

For SA LOC See ASAM Criteria Level 2.1. For Medicaid, FIDA and Dually Eligible members, please refer to the LOCADTR Criteria.

Intensive outpatient programs (IOP) offer short-term, multidisciplinary, structured day or evening programming that consists of intensive treatment and stabilization within an outpatient therapeutic milieu setting. IOP must be available at least 3 - 5 days per week. . Treatment reduces in intensity and frequency as the member establishes community supports and resumes daily activities. The short-term nature of IOPs makes it inappropriate to meet the need for long term day treatment. IOPs may be provided by either hospital- based or freestanding outpatient programs to members who experience symptoms of such intensity that they are unable to be safely treated in a less intensive setting and would otherwise require admission to a more intensive level of care. These programs also include 24/7 crisis management services, individual, group, and family therapy, coordination of medication evaluation and management services, as needed. Coordination with collateral contacts and care management/discharge planning services should also occur regularly as needed in an IOP. For children and adolescents, the IOP provides services similar to an acute level of care for those who members with supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child's caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1) Symptoms consistent with a DSM or corresponding ICD diagnosis. 2) Member is determined to have the capacity and willingness to improve or stabilize as a result of treatment at this level 3) Member has significant impairment in daily functioning due to psychiatric symptoms or substance use of such intensity that member cannot be managed in routine outpatient or lower level of care; 4) Member is assessed to be at risk of requiring a higher level of care if not engaged in intensive outpatient treatment; 5) There is indication that the member's psychiatric symptoms will improve within a reasonable time period so that the member can transition to outpatient or community based services; 6) Member's living environment offers enough stability to support intensive outpatient	**All of the following criteria must be met:** 1) Member continues to meet admission criteria. 2) Another less intensive level of care would not be adequate to administer care; 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely require a more intensive level of care; 4) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less intensive level of care; 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6) Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress towards a clearly defined and measurable goals; 7) Family/guardian/caregiver is participating in treatment as appropriate. 8) There is documentation around coordination of treatment with all involved parties	**Any one of the following: Criteria #1,2,3, or 4; criteria #5 and 6 are recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or guardian withdraws consent for treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan.

treatment. 7) Member's psychiatric/substance use/biomedical condition is sufficiently stable to be managed in an intensive outpatient setting. 8) Needed type or frequency of treatment is not available in or is not appropriate for delivery in an office or clinic setting **Exclusions** **Any** *of the following criteria is sufficient for exclusion from this level of care*: 1) The individual is a danger to self and others or sufficient impairment exists that a more intensive level of service is required. 2) The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications. 3) The individual requires a level of structure and supervision beyond the scope of the program. 4) The individual can be safely maintained and effectively treated at a less intensive level of care. 5) The primary problem is social, economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration. 6) The main purpose of the admission is to provide structure that may otherwise be achieved via community based or other services to augment vocational, therapeutic or social activities	including state/community agencies when appropriate; 9) The provider has documentation supporting discharge planning attempts to transition the member to a less intensive level of care	

Ambulatory Detoxification – See ASAM Level 1 Criteria. **For Medicaid, FIDA and Dually Eligible members, please refer to the LOCADTR Criteria.**

C. Day Treatment

The goal of day treatment is to assist children, adolescent with psychiatric disorders plus either an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms to improve functioning so that they can return to educational settings. Adolescents may continue to receive day treatment services over the age of 18, but under the age 22 if admission occurred prior to age of 18. Youngsters that benefit from behavioral health services that have significant challenges in educational settings would benefit from day treatment. Day treatment is focused on treatment services designed to stabilize the youth's adjustment to educational settings, to prepare children for return to education settings and assist with the transition. Services include health referral, medication therapy, verbal therapy, crisis intervention, case management, social, task and skill training and socialization.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria #1-7 must be met: 1. Member has an active DSM or corresponding ICD diagnosis (excluding mental retardation or other developmental disorders). 2. Member has an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms. 3. Member has the capacity to participate and benefit from day treatment. 4. Treatment at a less intensive level of care (LOC) would contribute to an exacerbation of symptoms. 5. The severity of presenting symptoms is such that member is unable to be adequately treated in a less intensive LOC. 6. Member requires individual intervention and/or part-time center based supervision for safety or to safely facilitate transition to a less intensive LOC. 7. Member's guardian is willing to participate in treatment, as appropriate.	**All of the following criteria must be met**: 1. Member continues to meet admission criteria; 2. Another less intensive LOC would not be adequate to administer care. 3. Treatment is still necessary to reduce symptoms and increase functioning for member to be treated at a less intensive LOC. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 6. Coordination of care and active discharge planning are ongoing, with goal of transitioning the member to a less intensive LOC.	**Criteria # 1, 2, 3, or 4 are suitable; criteria #5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in treatment plan. 4. Member is not making progress toward goals, nor is their expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's guardian in agreement with the aftercare treatment plan.

D. NMNC 3.303.0 Day Treatment

Day treatment services assist individuals in beginning the recovery and rehabilitative process, providing supportive, transitional services to members that are no longer acutely ill, but still require moderate supervision to avoid risk and/or continue to re-integrate into the community or workforce. This structured, activity-based setting is ideal for members that continue to have significant residual symptoms requiring extended therapeutic interventions. Day treatment is focused on the development of a member's independent living skills, social skills, self-care, management of illness, life, work, and community participation, thus maintaining or enhancing current levels of functioning and skills. Members participating in treatment have access to crisis management, individual group, family therapy, and coordination with collateral contacts as clinically indicated. Treatment declines in intensity as members develop skills and attain specific goals within a reasonable time frame allowing the transition to an outpatient setting with other necessary supports and longer-term supportive programming (i.e. clubhouse, employment, school, etc.).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1) Symptoms consistent with a DSM or ICD diagnosis. 2) Member's exacerbation or longstanding psychiatric disorder and level of functioning requires daily support and structure; 3) The member has the motivation and capacity to participate and benefit from day treatment. 4) Treatment at a less intensive level of care would contribute to an exacerbation of symptoms. 5) Member is assessed to be at risk of requiring a higher level of care if not engaged in day treatment services. 6) Member/guardian is willing to participate in treatment voluntarily 7) Member's psychiatric/substance use/biomedical condition is sufficiently stable to be managed in a day treatment setting. **Exclusions** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required. 2) The individual can be safely maintained and effectively treated at a less intensive level of care. 3) The individual does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment. 4) The individual requires a level of structure and supervision beyond the scope of the program.	**All of the following criteria must be met:** 1) Member continues to meet admission criteria. 2) Another less intensive level of care would not be adequate to administer care. 3) Treatment is still necessary to reduce symptoms and increase functioning for the member to be transitioned to a less restrictive setting. 4) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5) Family/guardian is participating in treatment as clinically indicated. 6) Coordination of care and active discharge planning are ongoing.	**Any one of the following: Criteria #1,2,3, or 4; criteria #5 and 6 are recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or guardian withdraws consent for treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan.

5) The individual has medical conditions or impairments that would prevent beneficial utilization of services. 6) The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration		

E. Personalized Recovery Orientated Services (PROS)

PROS programs offer a customized array of recovery-oriented services, both in traditional program settings and in off-site locations where people live, learn, work or socialize. The purpose of PROS is to assist individuals in recovering from the disabling effects of mental illness through the coordinated delivery of rehabilitation, treatment and support services. Goals for members in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing. There are four service components, including Community Rehabilitation and Support ("CRS"), Intensive Rehabilitation ("IR"), Ongoing Rehabilitation and Support ("ORS") and clinical treatment.

Intensive Rehabilitation consists of four different services. 1) Intensive Rehabilitation Goal Acquisition, 2) Intensive Relapse Prevention, 3) Family Psychoeducation, 4) Integrated Dual Disorder Treatment.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. The member has a designated mental illness diagnosis. 2. The member must be 18 years of age or older. 3. The member must be recommended for admission by a Licensed Practitioner of the Healing Arts. 4. The member exhibits functional deficits related to the severity and duration of a psychiatric illness in any of the following areas: self-care, activities of daily living, interpersonal relations, and/or adaptation to change or task performance in work or work-like settings. 5. Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP. 6. Admission begins when ISR is approved by MMCO/HARP. IRP must be developed within 60 days of admission date. 7. Active Rehabilitation begins when the Individualized Recovery Plan ("IRP") is approved by the MMCO/HARP and IRP indicates required services designed to engage and assist members in managing their illness and restoring those skills and supports necessary for living successful in the community. 8. The individual has developed or is interested in developing a recovery/life role goal. 9. There is not a lower level of care which is more appropriate to assist member with recovery goals.	**All of the following criteria must be met:** 1. The member continues to work towards goals, identified in an IRP. 2. Concurrent review and authorizations should occur at 3-month intervals for IR, ORS, and CR Services Continuing stay criteria may include: a. The member has an active recovery goal and shows progress toward achieving it; OR b. The member has met and is sustaining a recovery goal, but, would like to pursue a new goal; OR c. The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate; OR without PROS services the individual would require a higher level of care. 3. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.	**Any one of the following must be met:** 1. The member has sustained recovery goals for 6-12 months and a lower level of care is clinically indicated. 2. The member has achieved current recovery goals and can identify no other goals that would require additional PROS services. 3. The member is not participating in a recovery plan and is not making progress toward any goals. Extensive engagement efforts have been exhausted, and there is insignificant expected benefit from continued participation. 4. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

10. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.		

Ongoing Rehabilitation and Support (ORS) Criteria

Admission Criteria	Continued Stay Criteria	Discharge Criteria
One of the following criteria must be met: 1. Member has a specific goal related to employment. 2. Member would benefit from support in managing their symptoms in a competitive workplace. 3. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.	**Member continues to meet one of the following:** 1. Member continues to have a goal for competitive employment. 2. Member continues to benefit from supportive services in managing their symptoms in the competitive workplace. 3. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.	**Any one of the following must be met:** 1. The member no longer requires supportive services for managing symptoms in the competitive workplace. 2. The member no longer is seeking competitive employment. 3. The member has achieved current recovery goals and can identify no other goals that would require ongoing rehabilitation and support.

Intensive Rehabilitation (IR) Criteria

Admission Criteria	Continued Stay Criteria	Discharge Criteria
One of the following criteria must be met: 1. Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe. 2. The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention.	**Member continues to meet one of the following:** 1. Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe. 2. The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other	**Any one of the following must be met:** 1. The member is no longer at risk of hospitalization, involvement in criminal justice system and community tenure is assured in which intensive rehabilitation is no longer required. 2. The member has achieved current recovery goals and can identify no other goals that would require intensive rehabilitation. 3. The member can live, learn, work and socialize in the community with

3. Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure. 4. Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Dual Treatment. 5. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.	identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention. 3. Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure. 4. Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Dual Treatment. 5. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.	supports from natural and/or community resources without intensive rehabilitation.

F. Psychosocial Rehab (PSR)

Psychosocial Rehab services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in PSR treatment. 5. An individual must have the desire and willingness to receive rehabilitation and recovery services as part of their individual recovery plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a PRS level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without PRS services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional PSR services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

G. Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

An Intensive Psychiatric Rehabilitation Treatment program is time-limited with active psychiatric rehabilitation designed to assist an individual in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities from mental illness and to improve environmental supports. IPRT programs shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development, and discharge planning.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in IPRT treatment.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a IPRT level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without IPRT services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional IPRT services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

H. Community Psychiatric Support & Treatment (CPST)

Community Psychiatric Support & Treatment (CPST) includes time-limited goal directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site- based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in CPST treatment.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a CPST level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without CPST services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS level-of-care criteria. 2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional CPST services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

I. Assertive Community Treatment (ACT)

The purpose of Assertive Community Treatment (ACT) is to deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional service delivery approaches. ACT provides an integrated set of other evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of team meetings.

Initial Authorization Criteria	Continued Stay Criteria	Discharge Criteria
Criteria 1 - 5 must be met; **Criteria 6 & 7 may also be met:** 1. Severe and persistent mental illness (including, but, not limited to diagnoses of schizophrenia, schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression), that seriously impairs their functioning in the community. 2. Recipients with serious functional impairments should demonstrate at least one of the following conditions: a. Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives. b. Inability to be consistently employed at a self- sustaining level or inability to consistently carry out the homemaker role. c. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing). 3. Recipients with continuous high service needs should demonstrate one or more of the following conditions: a. Inability to participate or succeed in traditional, office-based services or case management. b. High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year). c. High use of psychiatric emergency or crisis services. d. Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues). e. Co-existing substance abuse disorder (duration greater than 6	1. Initial authorization criteria continue to be met. 2. A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals. Service plan is reviewed for progress and updated every 6 months as necessary 3. Continued coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc. 4. Active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC, when appropriate.	**Criteria 1, 2, 3, or 4 are suitable;** **Criteria 5 & 6 are recommended, but optional:** ACT recipients meeting any of the following criteria may be discharged: 1. Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service. 2. Individuals who move outside the geographic area of the ACT team's responsibility, subsequent to the transfer of care to another ACT team or other appropriate provider and continued services until the member is engaged in care. 3. Individuals who need a medical nursing home placement, as determined by a physician. 4. Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail. 5. Individuals who request discharge,

months). f. Current high risk or recent history of criminal justice involvement. g. Court ordered pursuant to participate in Assisted Outpatient Treatment. h. Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless. i. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. j. Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services. 4. Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision. 5. Member's condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions. 6. Member is stepping down from a higher level of care (LOC) and requires more intensive services than routine outpatient behavioral health treatment or other community based supports; and/or has past history of a similar clinical presentation where less intensive treatment was not sufficient to prevent clinical deterioration and the need for a higher LOC. 7. For children or adolescents, the parent or guardian agrees to participate in the member's treatment plan, as appropriate. 8. Priority is given to individuals with SMI, individuals with continuous high service needs that are not being met in more traditional service settings, and individuals with ACT in their AOT order 9. Exclusion criteria: Individuals with a primary diagnosis of a substance abuse disorder or mental retardation and members with a sole diagnosis of a personality disorder are not appropriate for ACT 10. The member is not enrolled in HCBS services other than crisis residential services.		despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a history of suicide, assault or forensic involvement. 6. Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons", including, but, not limited to, conferring with Health Homes and MMCO/HARPs, to which Member may be assigned.

SECTION III: EMERGENCY SERVICES

Overview

This section outlines services provided to members who are experiencing a behavioral health crisis and require an emergency evaluation.

A. Emergency Screening/Crisis Evaluations

Beacon promotes access to Emergency care without requiring prior authorization or notification from the member. Beacon, however, does require a face-to-face evaluation by a licensed clinician for all members requiring acute services. There is no level of care criteria for ESP services.

B. Comprehensive Psychiatric Emergency Program (CPEP)

Comprehensive Psychiatric Emergency Program (CPEP) is a licensed, hospital based psychiatric emergency program that establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Extended Observation Beds operated by the CPEP Program are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. There is no level of care criteria for CPEP services.

C. Mobile Crisis Intervention

Mobile Crisis Intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of

Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

D. Short Term Crisis Respite

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

E. Intensive Crisis Respite

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

SECTION IV: OUTPATIENT BEHAVIORAL HEALTH SERVICES

Overview

This chapter contains service descriptions and level of care (LOC) criteria for the following outpatient behavioral health services:

A. NMNC 5.501.0 Outpatient Services
B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)
C. NMNC 5.502.0 Psychological and Neuropsychological Testing
D. NMNC 6.604.0 Intensive Behavioral Intervention or Applied Behavioral Analysis
E. Developmental Screening
F. Psychiatric Home Care
G. Biofeedback

Beacon's utilization management of outpatient behavioral health services is based on the following principles:

- Outpatient treatment should result in positive outcomes within a reasonable time frame for specific disorders, symptoms and/or problems. The evaluation of goals and treatment should be based on the member's diagnosis, symptoms, and level of functioning;
- Treatment should be targeted to specific goals that have been mutually negotiated between provider and the member. Goals of initial and extended outpatient therapy may include crisis resolution, symptom reduction, stabilization, improvement in adaptation, and/or recovery from addiction;
- Treatment modality, frequency and length of treatment should be individualized for each member. Most clinical situations can be effectively managed using a short-term and/or intermittent model of treatment with varying modalities and frequency of contact, as needed;
- Individuals with chronic or recurring behavioral health disorders may require a longer term approach with intermittent visits over extended periods, or sustained contacts with increased intensity of services around periods of relapse or decompensation; and
- Members must have flexibility in accessing outpatient treatment, including transferring.

Please note that visits for psychopharmacology evaluation and management (E/M) and group therapy visits are not subject to this preauthorization process.

A. NMNC 5.501.0 Outpatient Services

Outpatient Behavioral Health treatment is an essential component of a comprehensive health care delivery system. Individuals with a major mental illness, chronic and acute medical illnesses, substance use disorders, family problems, and a vast array of personal and interpersonal challenges can be assisted in coping with difficulties through comprehensive outpatient treatment. The goal of outpatient behavioral health treatment is restoration, enhancement, and/or maintenance of a member's level of functioning and the alleviation of symptoms that significantly interfere with functioning. Efficiently designed outpatient behavioral health interventions help individuals and families effectively cope with stressful life situations and challenges. The goals, frequency, and length of treatment will vary according to the needs and symptomatology of the member. Telehealth services are services that can be provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating site) and a provider at a remote location (i.e., distant site).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All criteria must be met: 1) Member demonstrates symptoms consistent with a DSM or corresponding ICD diagnosis, and treatment focus is to stabilize these symptoms; 2) Member must be experiencing at least one of the following: a) A chronic affective illness, schizophrenia, or a refractory behavioral disorder, which by history, has required hospitalization. b) Moderate to severe symptomatic distress or impairment in functioning due to psychiatric symptoms in at least one area of functioning (i.e.. self-care, occupational, school, or social function). 3) There is an expectation that the individual: a) Has the capacity to make significant progress towards treatment goals; b) Requires treatment to maintain current level of functioning; c) Has the ability to reasonably respond and participate in therapeutic intervention. d) Would be at risk to regress and require a more intensive level of care 4) The member does not require a more intensive level of structure beyond the scope of non-programmatic outpatient services. 5) Medication management is not sufficient to stabilize or maintain member's current functioning;	**All of the following criteria must be met:** 1) Member's continues to meet admission criteria. 2) Member does not require a more intensive level or care, and no less intensive level of care would be appropriate to meet the member's needs. 3) Evidence suggests that the identified problems are likely to respond to current treatment plan; 4) Member's progress is monitored regularly, and the treatment plan is modified, if member is not making substantial progress toward a set of clearly defined and measurable goals. 5) Treatment planning includes family or other support systems unless not clinically indicated. 6) Frequency and intensity of treatment contact occurs at a rate that is appropriate to the severity of current symptoms (intermittent treatment allowing the member to function with maximal independence is the goal); and a lower frequency of sessions not would be sufficient to meet the member's needs.	**Criteria #1 and any one of # 2 - 9 must be met:** 1) Member has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others. 2) Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care. 3) Member has substantially met the specific goals outlined in treatment plan (there is resolution or acceptable reduction in target symptoms that necessitated treatment). 4) Member is competent and non-participatory in treatment, or the individual's non-participation is of such degree that treatment at this level of care is rendered ineffective or unsafe despite multiple documented attempts to address non-participation issues. 5) Evidence does not suggest that

Admission Criteria	Continued Stay Criteria	Discharge Criteria
6) The member is likely to benefit from and respond to psychotherapy due to diagnosis, history, or previous response to treatment; 7) The member cannot be adequately stabilized in a rehabilitative or community service setting to assist with: health, social, occupational, economic, or educational issues. 8) Treatment is not being sought as an alternative to incarceration. **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual requires a level of structure and supervision beyond the scope of non- programmatic outpatient services 2) The individual has medical conditions or impairments that would prevent beneficial utilization of services 3) The primary problem is social, occupational, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration. 4) Treatment plan is designed to address goals other than the treatment of active symptoms of DSM or corresponding ICD diagnosis (e.g. self-actualization). 5) Medication Management level of outpatient care is sufficient to stabilize or maintain the individual's functioning once an episode of active psychotherapy has been completed, or if it is unlikely that psychotherapy would be of benefit given the individual's diagnosis, history, or previous response to treatment. 6) Rehabilitative or community services are provided and are adequate to stabilize or assist the individual in resuming prior level of roles and responsibility.	7) Evidence exists that member is at current risk of a higher level of care if treatment is discontinued. 8) When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner. 9) There is documented active discharge planning from the beginning of treatment.	the defined problems are likely to respond to continued outpatient treatment. 6) Member is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment approach. 7) Current treatment plan is not sufficiently goal oriented and focused to meet behavioral objectives. 8) Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for inpatient level of care. 9) It is reasonably predicted that maintaining stabilization can occur with discharge from care and/or Medication Management only and community support.

B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)

Home-Based Therapy (HBT) is a short term service for members who require additional support to:

- successfully transition from an acute hospital setting to their home and community, or
- Safely remain in their home or community when they experience a temporary worsening, or new behavioral health need, that may not be emergent, but without timely intervention could result in the need for a more intensive level of care than traditional outpatient treatment.

HBT brings the clinician to the member when there are delays or barriers to the member's timely access to a therapist. The HBT appointment is scheduled to occur within 48 hours of discharge from an acute mental health inpatient setting. The Beacon UR clinician may request that the HBT nurse/therapist visit the member in the hospital prior to discharge to explain HBT and ensure the member's willing participation in the service. This level of care (LOC) requires a safe home environment that poses no safety risk to the HBT clinician. The HBT clinician does not replace the outpatient therapist, but reinforces the aftercare plan, assists to overcome any potential or identified barriers to care, helps identify resources for necessary community-based services, and bridges any delays or gaps in service. The HBT clinician may also work with the member's family to increase understanding of the member's condition and the importance of adherence. HBT may also be deployed to help a member avert acute hospitalization during a brief period of destabilization.

Home Based Therapy-Plus (HBTP)

HBTP is appropriate for members who meet the following criteria:

History of treatment non- which has resulted in poor functionality in the community

1. HBPT is available for members who History of 2 or more admissions in less then 12 months
2. Presence of co-occurring medical and BH disorders
3. First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria # 1 - 5 must ALL be met; and at least one of criteria # 6 – 7 must also be met: 1. Member must have a DSM or corresponding ICD diagnosis of a psychiatric disorder. 2. Member can be maintained adequately and safely in their home environment. 3. Member has the capacity to engage and benefit in treatment. 4. Member agrees to participate in psychiatric home based treatment. 5. Member's level of functioning in areas such as self-care, work, family living, and social relations is impaired. 6. Member has social/emotional barriers that cannot be	**Criteria # 1 - 6 must ALL be met:** 1. Member continues to meet admission criteria and another less intensive LOC is not appropriate. 2. Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC. 3. Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 4. Member appears to be benefiting from	**Criteria # 1, 2, 3 or 4 are suitable; Criteria # 5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member and/or parent/caregiver do not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and

adequately managed in an office based program setting. 7. Member has history of non-compliance in terms of routine office based services which has recently resulted in placement in a more intensive LOC. **For HBTP, at least one from Criteria 8 through 11 must also be met:** 8. History of 2 or more admissions in less than 12 months 9. Presence of co-occurring medical and BH disorders. 10. First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression 11. History of treatment non- which has resulted in poor functionality in the community	the service. 5. Member is compliant with treatment plan and continues to be motivated for services. 6. Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC.	goals have been met. 6. Member's support system is in agreement with the aftercare treatment plan.

C. NMNC 5.502.0 Psychological and Neuropsychological Testing

Psychological and neuropsychological testing is the use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning. A licensed psychologist performs psychological testing, either in independent practice as a health services provider, or in a clinical setting. Psychology assistants (Doctoral level or Doctoral candidates) may test members and interpret test results; provided the evaluation is conducted in a clinical setting, and that the testing is directly supervised and co-signed by a qualified licensed psychologist. Psychology assistants may not test members under the supervision of a psychologist in an independent practice setting. Neuropsychological testing is most often utilized for members with cognitive impairments that impede functioning on a day to day basis. These members usually do not have other clinical treatment.

All testing is subject to the admission and criteria below, however the following guidelines are most common testing issues:

- Testing is approved only for licensed psychologists and other clinicians for whom testing falls within the scope of their clinical license and have specialized training in psychological and/or neuropsychological testing
- **Educational testing** is not a covered benefit, though this may be subject to state and account-specific arrangements. Assessment of possible learning disorder or developmental disorders is provided by school system per federal mandate PL 94-142
- When **neuropsychological testing** is requested secondary to a clear, documented neurological injury or other medical/neurological condition (i.e.. Stroke, traumatic brain injury multiple sclerosis), this may be referred to the medical health plan, though this determination may be subject to state and account-specific guidelines. Neurology consult may be required prior to request.
- All tasks involving **projective testing** must be performed by a licensed psychologist or other licensed clinician with specialized training in projective testing and who is permitted by state licensure.
- The expectation is that diagnosis of ADHD can be made by a psychiatric consult and may not require psychological testing.
- Testing requested by the legal or school system is not generally a covered benefit.

Admission Criteria	Criteria for Tests	Non-Reimbursable Tests
The following criteria must apply: **Psychological Testing #12 and 3 must be met:** 1) Request for testing is based on need for at least one of the following: a) Differential diagnosis of mental health condition unable to be completed by traditional assessment; b) Diagnostic clarification due to a recent change in mental status for appropriate level of care determination/treatment needs due to lack of standard treatment response.	1) Tests must be published, valid, and in general use as evidenced by their presence in the current edition of the *Mental Measurement Yearbook*, or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological	1) Self-rating forms and other paper and pencil instruments, unless administered as part of a comprehensive battery of tests, (e.g., *MMPI* or *PIC)* as a general rule. 2) Group forms of intelligence tests. 3) Short form, abbreviated, or "quick" intelligence tests administered at the same time as the *Wechsler* or *Stanford-Binet* tests. 4) A repetition of any psychological tests or tests provided to the same member within the

2) Repeat testing needed as indicated by **ALL** of the following a) Proposed repeat psychological testing can help answer question that medical, neurologic, or psychiatric evaluation, diagnostic testing, observation in therapy, or other assessment cannot. b) Results of proposed testing are judged to be likely to affect care or treatment of member (eg, contribute substantially to decision of need for or modification to a rehabilitation or treatment plan). c) Member is able to participate as needed such that proposed testing is likely to be feasible (eg, appropriate mental status, intellectual abilities, language skills). d) No active substance use, withdrawal, or recovery from recent chronic use and e) Clinical situation appropriate for repeat testing as indicated by **1 or more** of the following: i. Clinically significant change in member's status (eg, worsening or new symptoms or findings) ii. Other need for interval reassessment that will inform treatment plan 3) The member must have: a) Current active treatment and a diagnostic evaluation (including psychosocial functioning); b) Evaluation by a psychiatrist prior to testing; c) Requests for educational purposes, must be within state testing mandates d) No active illicit substance use within 3 months of request. **Neuropsychological Testing #4 and 5 must be met:** 4) The member is experiencing cognitive impairments; 5) The member has had a comprehensive evaluation by a psychiatrist, psychologist, or developmental/behavioral pediatrician;	Association. 2) Tests are administered individually and are tailored to the specific diagnostic questions of concern.	preceding six months, unless documented that the purpose of the repeated testing is to ascertain changes: a. Following such special forms of treatment or intervention such as ECT; b. Relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. 5) Tests for adults that fall in the educational arena or in the domain of learning disabilities. 6) Testing that is mandated by the courts, DSS or other social/legal agency in the absence of a clear clinical rationale. **Please Note:** Beacon will *not* authorize periodic testing to measure the member's response to psychotherapy.

Exclusions: ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) Testing is primarily to guide the titration of medication. 2) Testing is primarily for legal purposes. 3) Testing is primarily for medical guidance, cognitive rehabilitation, or vocational guidance, as opposed to the **admission criteria** purposes stated above. 4) Testing request appears more routine than medically necessary (e.g., a standard test battery administered to all new members). 5) Specialized training by provider is not documented. 6) Interpretation and supervision of neuropsychological testing (excluding the administration of tests) is performed by someone *other than* a licensed psychologist or other clinician whom neuropsychological testing falls within the scope of their clinical license, and who has had specialized in neuropsychological testing. 7) Measures proposed have no standardized norms or documented validity. 8) The time requested for a test/test battery falls outside Beacon Health Options' established time parameters. 9) Extended testing for ADHD has been requested prior to provision of a thorough evaluation, which has included a developmental history of symptoms and administration of rating scales. 10) Symptoms of acute psychosis, confusion, disorientation, etc., interfering with proposed testing validity are present. 11) Administration, scoring and/or reporting of projective testing is performed by someone other than a licensed psychologist, or other clinician for whom psychological testing falls within the scope of their clinical licensure and who has specialized training in psychological testing.		

D. NMNC 6.604.0 Intensive Behavioral Intervention or Applied Behavioral Analysis

Intensive Behavioral Intervention (IBI) or Applied Behavioral Analysis (ABA) is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behavior and address challenging behavior problems for members with Autism Spectrum Disorders. Often the behavioral challenges are of such intensity that the member's ability to participate in common social activities or education settings is not possible. ABA services include the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment of ABA focuses on treating these behavioral issues by changing the individual's environment. Suggested intensity and duration of applied behavioral analysis (ABA) varies and is not clearly supported by specific evidence; however, most guidelines and evidence reviews suggest at least 15 hours per week over 1 to 4 years, depending on a child's response to treatment (e.g., adjust or discontinue treatment if child not responding as determined by validated objective standards and outcome measures). Systematic reviews and meta-analyses of studies of early intervention ABA found that mean age of members ranged from 18 to 84 months, mean treatment intensity ranged from 12 to 45 hours per week, and treatment duration ranged from 4 to 48 months.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following must be met: 1) The member has behavioral symptoms consistent with a DSM or corresponding ICD diagnosis for Autism Spectrum Disorders as determined by a qualified provider including a pediatrician, independently licensed and credentialed psychologist, or as permitted by state or federal law; 2) Member has specific challenging behavior(s) and/or level of functional deficits attributable to the autism spectrum disorder (e.g. self-injurious, stereotypic/repetitive behaviors, aggression toward others, elopement, severely disruptive behaviors) which result(s) in significant impairment in one or more of the following: a) personal care b) psychological function c) vocational function d) educational performance e) social function f) communication disorders 3) The member can be adequately and safely maintained in their home environment and does not require a more intensive level of care due: imminent risk to harm self or others or severity of	**All of the following must be met:** 1) Member continues to meet admission criteria; 2) There is no other level of care that would more appropriately address member's needs; 3) Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated in a less restrictive level of care; 4) Treatment/intervention plan include age appropriate, clearly defined behavioral interventions with measurable goals to target problematic behaviors. 5) Member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward	**Any one of the following: Criteria # 1, 2, 3, 4, 5, or 6 are; Criterion # 7 is recommended, but optional:** 1) Member no longer meets admission criteria and/or meets criteria for another level of care. 2) Member's individual treatment plan and goals have been met. 3) Parent / guardian / caregiver is capable of continuing the behavioral interventions. 4) Parent/guardian withdraws consent for treatment 5) Member or parent/guardian/caregiver does not appear to be participating in treatment plan and/or be involved in behavior management training. 6) Member is not making progress toward goals, nor is there any expectation of progress.

maladaptive behaviors. 4) The member's challenging behavior(s) and/or level of functioning is expected to improve with IBI/ABA 5) Family/caregiver is willing to participate in member's treatment and skill building unless not clinically indicated. 6) The member is not currently receiving any other in home or office-based IBI/ABA services. **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual has medical conditions or impairments that would prevent beneficial utilization of services. 2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. 3) The following services are not included within the ABA treatment process and will not be certified: a) Speech therapy (may be covered separately under health benefit) b) Occupational therapy (may be covered separately under health benefit) c) Physical Therapy d) Vocational rehabilitation (may be covered separately under health benefit) e) Supportive respite care f) Recreational therapy g) Orientation and mobility h) Respite care i) Equine therapy/Hippo therapy j) Dolphin therapy k) Other educational services	decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives. 6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 7) Parent / guardian / caregiver are involved in training in behavioral interventions and continue to participate in and be present for treatment sessions as appropriate. Progress of parent skill development in behavior management interventions is being monitored 8) Coordination of care and discharge planning are ongoing with the goal of transitioning member to a less intensive behavioral intervention and a less intensive level of care.	7) Member's support system is in agreement with the transition/discharge treatment plan.

E. Developmental Screening (article 28 and 31 clinics only)

Developmental screening

Developmental screening provides parents and professionals with information on whether a child's development is similar to other children of the same age. Screening always involves the use of a standardized tool. Screening tool questions are based on developmental milestones and designed to answer the question, "Is this child's development like other children of the same age?" Ideally, screening is an ongoing process involving repeat administration of a tool, along with continuous, quality observations made by adults familiar with the child.

Screening does not give a diagnosis, but identifies areas in which a child's development differs from same-age norms. Concerning screening results indicate the need for further assessment to determine a child's strengths and needs.

To read The American Academy of Pediatrics definition of developmental screening, click here (http://www.aap.org/healthtopics/early.cfm). The AAP now recommends developmental screening of all children at ages 9-, 18-, and 30-months. Targeted screening happens when screening is conducted because of concerns about a child.

Article 28 and 31 clinics will be reimbursed for up to 4 units (hours) of developmental screening without prior authorization. For additional units, providers may request the Developmental Screening Supplemental Form.

F. Psychiatric Home Care

Psychiatric Home Care is treatment that is delivered in a member's home or in their living environment in order to treat a DSM or corresponding ICD diagnosis. This service must be provided by an accredited home care agency and the clinical service must be provided by a licensed mental health professional. Psychiatric Home Care may be authorized for a variety of circumstances (e. g., member is homebound or has difficulty ambulating or is unlikely to get to the community mental health provider). For all home care agencies, a written physician order for Psychiatric Home Care services must be in place at the time the service is requested and a physician must be available for consultation and is integrated into treatment plan. The frequency of visits varies depending on level of acuity.

- **Authorization Procedures -** Beacon requires a call from the provider to pre-certify a psychiatric home care evaluation. After the evaluation is completed, the provider will call with clinical information including the member's diagnosis, treatment plan and discharge plan.
- **Written Notification -** Beacon sends an authorization letter to the Provider, including the Prior Authorization Number within 1 business day after the review is completed.
- **Extension requests -** Prior to the end date of the existing authorization, the Provider may request an extension of services.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Criteria # 1 -6 must ALL be met: 1. Member must have a DSM or corresponding ICD diagnosis. 2. Member can be adequately and safely maintained in the home environment. 3. Member is motivated to receive this service and is willing to participate and comply with the developed treatment plan. 4. Member requires coordination of services with other providers and other support services. 5. Member requires assistance to adhere to safe administration of medication regimen. 6. Psychiatric home care is believed to be necessary to prevent placement in a higher level of care.	**Criteria # 1 - 7 must ALL be met and at least one from criteria # 8- 9 must be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate. 2. Treatment is still necessary to reduce symptoms and improve functioning. 3. Member progress is monitored regularly, and the treatment plan modified, toward a set of clearly defined and measurable goals. 4. Member appears to be benefiting from the service. 5. Member is compliant with treatment plan and continues to be motivated for services. 6. Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC. 7. Continuation of psychiatric home care is believed to be necessary in order to prevent placement in a higher LOC. 8. Member has complex co-morbid issues that require skilled nursing and behavioral health supervision. 9. Member is still not able to follow medication regimen without this level of support (and there is a lack of social support at home.)	**Criteria # 1, 2, or 3, are suitable; criteria # 4 and 5 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or guardian withdraws consent for treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member's individual treatment plan and goals have been met. 5. Member's support system is in agreement with the aftercare treatment plan.

OPIOID REPLACEMENT THERAPY

Opioid replacement therapy is the medically monitored administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA) approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines medical and pharmacological interventions with counseling, educational and vocational services and is offered on a short term (detoxification) and long term (maintenance) basis.

Buprenorphine Maintenance Treatment (BMT) - See ASAM Level 1 Criteria. For Medicaid, FIDA and Dually Eligible members, please refer to the LOCADTR Criteria.

G. Biofeedback

Biofeedback is a process that enables an individual to learn how to change physiological activity for the purpose of improving health and performance. Precise instruments measure physiological activity such as brainwaves, heart function, breathing, muscle activity and skin temperature. These instruments rapidly and accurately "feed back" information to the user. The presentation of this information – often in conjunction with changes in thinking emotions and behavior – supports desired physiological changes. Over time these changes can endure without continued use of an instrument. (Association for Applied Psychophysiology and Biofeedback, 2008).

Important: While level of care determinations are considered in the context of an individual's treatment history; Beacon Health Strategies never requires the attempt of a less intensive treatment as a criterion to authorize any service.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
Either 1 or 2 and 3 are necessary for admission: 1. Biofeedback is a listed covered benefit with no specific included diagnoses and is being requested for the treatment of an Anxiety Disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and can be reasonably expected to respond to this treatment modality as a component of a comprehensive treatment plan. 2. Biofeedback is a covered benefit with specific included diagnoses and the request for services is for a covered diagnosis listed in the most recent DSM; and can be reasonably expected to respond to this treatment modality as a component of a comprehensive treatment plan. 3. There are significant symptoms that interfere with the individual's ability to function in at least one life area. **Note:** These factors may affect the treatment plan and should be considered when making decisions.	1. The individual continues to meet admission criteria for Biofeedback. 2. The individual does not require a more intensive level of care or service, and no less intensive services are appropriate. 3. The frequency of sessions is occurring or scheduled to occur at a rate that is appropriate to the individual's current symptoms, and no less frequency of sessions would be sufficient to meet their needs. 4. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. 5. All services and treatment are carefully structured to achieve optimum results in the most efficient manner possible, consistent with sound clinical practice. Expected benefit from the Biofeedback is documented. 6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident. OR a. Progress toward stabilization of	**Any of the following criteria are sufficient for discontinuation from this service:** 1. The individual's documented treatment plan goals and objectives have been substantially met. 2. The individual no longer meets admission criteria, or meets criteria for a less or more intensive service or level of care. 3. The individual is competent and non-participatory in treatment, or the individual's non-participation is of such degree that treatment is rendered ineffective, or unsafe despite multiple, documented attempts to address non-participation issues. 4. Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision. 5. The individual is not making progress toward treatment goals, and there is no reasonable expectation of progress with this treatment approach. 6. It is reasonably predicted that continuing stabilization can occur with discontinuing Biofeedback with ongoing medication management and/or psychotherapy and community support.

Exclusions: ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1. Biofeedback is being requested for a physical health condition (request should be directed to medical plan). 2. The individual has conditions or impairments that would prevent beneficial utilization of Biofeedback. 3. Biofeedback is being requested for any behavioral health diagnosis except one specifically listed as a benefit or an Anxiety Disorder in the absence of specifically covered diagnoses listed in the most recent version of the DSM. 4. Biofeedback is not being used as an adjunctive treatment in a comprehensive treatment regimen. 5. Standard accepted outpatient treatments (including psychotherapy and medication management) are sufficient to safely and effectively treat the individual.	functioning is documented OR b. Continued Biofeedback is expected to prevent the need for more intensive services or levels of care. 7. Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan. 8. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner. 9. There is documented active discharge planning from the beginning of treatment, which includes ensuring the ability of the individual to continue the Biofeedback learned techniques independently after discharge.	

SECTION V: OTHER SPECIAL BEHAVIORAL HEALTH SERVICES

Overview

This chapter contains other special Behavioral Health service descriptions and level of care criteria for the following:

A. NMNC 6.601.0 Electro-Convulsive Therapy
B. Pre-vocational Services
C. Transitional Employment
D. Intensive Supported Employment (ISE)
E. Ongoing Supported Employment
F. Education Support Services
G. Empowerment Services - Peer Supports
H. Habilitation/Residential Support Services
I. Family Support and Training
J. NMNC 6.602.0 Repetitive Transcranial Magnetic Stimulation
K. Home and Community Based Services

Please note: Use of this level of care is specific to a Health Plans authorization requirements.

A. NMNC 6.601.0 Electro-Convulsive Therapy

Electro-Convulsive (ECT) Therapy is a procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity while the member is under anesthesia. This procedure can be administered in a variety of settings, ranging from a licensed hospital to outpatient settings. The principal indication for ECT is major depression with melancholia. The symptoms that predict a good response to ECT are: early morning awakening, impaired concentration, pessimistic mood, motor restlessness, speech latency, constipation, anorexia, weight loss, and somatic or self-deprecatory delusions, all occurring as part of a depressive acute illness. The decision to pursue ECT treatments is based on a risk/benefit analysis based on the member's history, medical issues, symptomatology, and anticipated adverse side effects. Providers must complete a work-up including medical history, physical examination, and any indicated pre-anesthetic lab work to determine whether there are contraindications to ECT-related anesthesia and that there are no less intrusive alternatives before scheduling administration of ECT. The member must provide separate written informed consent to ECT on forms provided by the specific state mental health agency, as consent to other forms of psychiatric treatment are considered separate. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments.

Initial Authorization Criteria	Continued Authorization Criteria	Discontinuation Criteria
All of the following criteria must be met: 1) DSM or corresponding ICD diagnosis of major depression, schizophrenia, schizoaffective mood disorder , or other disorder with features that include mania, psychosis, and/or catatonia; 2) Member has been medically cleared and there are no contraindications to ECT (i.e.Intracranial or cardiovascular, or pulmonary contraindications); 3) There is an immediate need for rapid, definitive response due to at least one of the following: a) Severe unstable medical illness; b) Significant risk to self or others; c) catatonia d) Other somatic treatments could potentially harm the member due to slower onset of action. 4) The benefits of ECT outweigh the risks of other treatments as evidenced by at least one of the following: a) Member has not responded to adequate medication trials; b) Member has had a history of positive response to ECT 5) Maintenance ECT, as indicated by all of the following a) Without maintenance ECT member is at risk	**All of the following criteria must be met:** 1) The member continues to meet admission criteria; 2) An alternative treatment would not be more appropriate to address the members ongoing symptoms; 3) The member is in agreement to continue treatment of ECT; 4) Treatment is still necessary to reduce symptoms and improve functioning; 5) There is evidence of subjective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress; 6) The total number of treatments administered is proportional to the severity of symptoms, rate of clinical improvement, and adverse side effects; 7) There is documented coordination with family and community supports as clinically appropriate; 8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	**Any one or more of the following criteria**: 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member withdraws consent for treatment and does not meet criteria for involuntary mandated treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's natural support (or other support) systems are in agreement with following through with member care, and the member is able to be in a less restrictive environment

relapse b) Adjunct therapy to pharmacotherapy c) Sessions tapered to lowest frequency that maintains baseline **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual can be safely maintained and effectively treated with a less intrusive therapy; or 2) Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific individual from this level of care. Such conditions include but are not limited to: a) unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease; b) aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure; c) increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions; d) recent cerebral infarction; e) pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia; and anesthetic risk rated as American Society of Anesthesiologists level 4 or 5		

B. Pre-vocational Services

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

C. Transitional Employment

Transitional Employment services are designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

D. Intensive Supported Employment (ISE)

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

E. Ongoing Supported Employment

Ongoing supported Employment is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for

the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

F. Education Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

G. Empowerment Services - Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

H. Habilitation/Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community based settings.

These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

I. Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team.

Please note: Use of this level of care is specific to a Health Plans authorization requirements.

J. NMNC 6.602.0 Repetitive Transcranial Magnetic Stimulation

Description of Services: Repetitive Transcranial Magnetic Stimulation (rTMS) is a noninvasive method of brain stimulation. In rTMS, an electromagnetic coil is positioned against the individual's scalp near his or her forehead. A Magnetic Resonance Imaging (MRI)-strength, pulsed, magnetic fields then induce an electric current in a localized region of the cerebral cortex, which induces a focal current in the brain and temporary modulation of cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Depending on stimulation parameters, repetitive TMS to specific cortical regions can either decrease or increase the excitability of the targeted structures. It is thought that this stimulates the part of the brain that involves mood control and can ease depression. This is a treatment that could be tried when other depression treatments have not worked. rTMS does not induce seizures or involve complete sedation with anesthesia like are involved with ECT. rTMS is usually administered four to six times per week and for six weeks or less. It is typically performed in an outpatient office. rTMS is not considered proven for maintenance treatment. The decision to recommend the use of rTMS derives from a risk/benefit analysis for the specific member. This analysis considers the diagnosis of the member and the severity of the presenting illness, the member's treatment history, any potential risks, anticipated adverse side effects and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

Initial Authorization Criteria	Continued Authorization Criteria	Discharge Criteria
All of the following criteria must apply: 1) The member must be at least 18 years of age. 2) The individual demonstrates behavioral symptoms consistent with unipolar Major Depression Disorder (MDD), severe degree without psychotic features, either single episode or recurrent, as described in the most current version of the DSM ,or corresponding ICD, and must carry this diagnosis. 3) Depression is severe as defined and documented by a validated, self-administered, evidence-based monitoring tool (e.g QID-SR16, PHQ-9, HAM-D or BDI, etc). 4) The diagnosis of MDD cannot be made in the context of current or past history of manic, mixed or hypomanic episode. 5) The member has no active (within the past year) substance use or eating disorders. 6) Member must exhibit treatment-resistant depression in the current treatment episode with all of the following: a) Lack of clinically significant response (less than 50% of depressive symptoms) b) Documented symptoms on a valid, evidence-based monitoring tool; c) Medication adherence and lack of response to at least 4 psychopharmacologic trials in the current episode of treatment at the minimum dose and from 2 different medication classes; 7) History of response to TMS in a previous depressive episode as evidenced	**All of the following criteria must be met:** 1) The member continues to meet admission criteria; 2) An alternative treatment would not be more appropriate to address the members ongoing symptoms; 3) The member is in agreement to continue TMS treatment and has been adherent with treatment plan; 4) Treatment is still necessary to reduce symptoms and improve functioning; 5) There is evidence of objective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress; 6) The total number of treatments administered is proportional to the rate of clinical improvement	**Any one of the following criteria:** 1) The individual has achieved adequate stabilization of the depressive symptoms 2) Member withdraws consent for treatment 3) Member no longer meets authorization criteria and/or meets criteria for another level of care, either more or less intensive. 4) The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement (e.g. validated rating scale and behavioral description) and there is no reasonable expectation of progress.

by a greater than 50% response in standard rating scale for depression (e.g., Geriatric Depression Scale (GDS), Personal Health Questionnaire Depression Scale (PHQ-9), Beck Depression Scale (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory for Depressive Symptomatology Systems Review (IDS-SR) and now has a relapse after remission and meets all other authorization criteria. 8) There is no history of the following: a) Previous response to ECT b) Seizures or neurologic conditions such as epilepsy, febrile seizures in infancy; c) Cerebrovascular disease; d) Dementia, e) Increased intracranial pressure, repetitive head trauma, or tumors in the central nervous system. f) Implanted medical device or magnetic-sensitive materials or dental implants less than 30 cm from rTMS magnetic coil 9) rTMS is administered by a US Food and Drug Administration (FDA) cleared device for the treatment of MDD in a safe and effective manner according to the manufacturer's user manual and specified stimulation parameters. 10) The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy and directly supervises the procedure (on site and immediately available) **Exclusions:** ***Any*** *of the following criteria are sufficient for exclusion from this level of care:* 1) The individual has medical conditions or impairments that would prevent beneficial utilization of services 2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. The safety and effectiveness of rTMS has not been established in the following member populations or clinical conditions through a controlled clinical trial, therefore the following are exclusion criteria:	and severity of adverse side effects; 7) There is documented coordination with family and community supports as appropriate; 8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	5) Worsening of depressive symptoms such as increased suicidal thoughts/behaviors or unusual behaviors.

3) Members who have a suicide plan or have recently attempted suicide 4) Members who do not meet current DSM or corresponding ICD criteria for major depressive disorder 5) Members younger than 18 years of age or older than 70 years of age 6) Members with history recent history of active of substance abuse, obsessive compulsive disorder or post-traumatic stress disorder 7) Members with a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features. 8) Members with neurological conditions that include epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS. 9) The presence of vagus nerve stimulator leads in the carotid sheath 10) The presence of metal or conductive device in their head or body that is contraindicated with rTMS. For example, metals that are within 30cm of the magnetic coil and include but are not limited to cochlear implant, metal aneurysm coil or clips, bullet fragments, pacemakers, ocular implants, facial tattoos with metallic ink, implanted cardioverter defibrillator, metal plates, vagus nerve stimulator, deep brain stimulation devices and stents. 11) Members with Vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators. 12) Members with major depressive disorder who have failed to receive clinical benefit from ECT or VNS. 13) Presence of severe cardiovascular disease. 14) Members who are pregnant or nursing. 15) rTMS is not indicated for maintenance treatment. An extensive review of the published peer reviewed medical literature found no double blind clinical trials looking at the efficacy of rTMS in preventing relapse in those members who have responded. rTMS for maintenance treatment of major depressive disorder is experimental/investigational due to the lack of demonstrated efficacy in the published peer reviewed literature.		

K. HOME AND COMMUNITY BASED SERVICES – Review Guidelines and Criteria

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in a Health and Recovery Plan (HARP) to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders.

These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is a collaboration between all pertinent participants including but not limited to the Health Home care manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member's chosen goals. These conversations will focus on the member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

HCBS eligibility will be determined using a standard needs assessment tool, typically administered by the individual's Health Home (HH) care manager. Provision of Home and Community Based Services requires a person-centered approach to care planning, service authorizations, and service delivery. MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual (latest version available at: https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/). This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals and preferences, and also ensures member choice of service options and providers.

Criteria for HCBS services were developed in collaboration with the State of New York and are only edited in with their agreement.

The following is a description of the various HCBS services.

1) Community Rehabilitation Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum, and as such, Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) are designated as a cluster.

a. Psychosocial Rehabilitation (PSR):

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

b. Community Psychiatric Support and Treatment (CPST):

CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site- based programs who

can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

2) Vocational Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment.

a. Pre-vocational Services:

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

b. Transitional Employment (TE)

This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center

This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

c. Intensive Supported Employment (ISE)

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the

customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

d. Ongoing Supported Employment

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

3) <u>Short-Term Crisis Respite Services</u>

a. Short-term Crisis Respite

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Short-Term Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

b. Intensive Crisis Respite

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Intensive Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service.

4) <u>Education Support Services</u>

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

5) Empowerment Services - Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

6) Habilitation / Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the participant.

7) Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the participant. Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual's recovery plan and for the benefit of the Medicaid covered participant.

Admission Criteria:	Continued Stay Criteria:	Discharge Criteria:
All of the following criteria must be met: 1. The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool. 2. Where the member has been deemed eligible to receive services, a full HCBS Assessment has been completed to determine these services are appropriate for that individual. 3. A Plan of Care has been developed, informed and signed by the member, Health Home care manager, and others responsible for implementation. The POC has been approved by the Plan. 4. The HCBS provider develops an Individual Care Plan (ICP) that is informed and signed by the member and HCBS provider staff responsible for ISP implementation. 5. The ISP and subsequent service request supports the member's efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community. 6. The member must be willing to receive home and community based services as part of their ISP. 7. There is no alternative level of care or co-occurring service that would better address the member's clinical needs as shown in POC and ISP.	All of the following criteria must be met: 1. Member continues to meet admission criteria and an alternative service would not better serve the member. 2. Interventions are timely, need based, and consistent with evidence based/best practice and provided by a designated HCBS provider. 3. Member is making measureable progress towards a set of clearly defined goals; Or There is evidence that the service plan is modified to address the barriers in treatment progression Or Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration. 4. There is care coordination with physical and behavioral health providers, State, and other community agencies. 5. Family/guardian/caregiver is participating in treatment where appropriate.	Criteria #1, 2, 3, 4, or 5 are suitable; criteria #6 is recommended, but optional: 1. Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in the ISP. 4. Member's needs have changed and current services are not meeting these needs. Member's self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge alternative services are being explored in collaboration with the member, family members (if applicable), the member's Health Home and HCBS provider and MCO. 5. Member's ISP goals have been met. 6. Member's support system is in agreement with the aftercare service plan.