



Iowa Plan for Behavioral Health Utilization Management Guidelines 2015

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Preface

Our purpose in releasing the *Iowa Plan for Behavioral Health Utilization Management Guidelines* is to inform the practitioner of the parameters that Magellan Behavioral Care of Iowa, Inc. (Magellan) reviews in determining the appropriate services and level/site of care for reimbursement purposes. The practitioner should use these guidelines to support rather than substitute for sound clinical judgment. Ultimate treatment decisions rest with the practitioner. Magellan will not be held responsible or liable for any use or misuse of the guidelines.

NOTE: Our release of these guidelines constitutes a license to the practitioner to use them solely to assist in the planning treatment of the practitioner's own members. Individuals or organizations engaged in providing case management or utilization review services on behalf of others may not use these guidelines. Any unauthorized use or copying is prohibited. If you are interested in licensing the guidelines for purposes other than those expressly permitted herein, please contact Magellan.

Magellan encourages comments and suggestions from the professional community regarding improvements to the *Utilization Management Guidelines*. You can send your comments to Magellan at the following address:

Magellan Behavioral Care of Iowa, Inc.
Quality Improvement Department
2600 Westown Parkway, Suite 200
West Des Moines, IA 50266.

Overview

Magellan is committed to the delivery of the highest quality health care. This overview highlights the features of the approach to managed care for mental health and substance use disorders that are unique to Magellan. Our mission statement reads as follows:

“Our mission is to help in promoting the recovery of all our members. We believe in promoting resiliency skill and coping abilities for an improved future. An emphasis on strengths and natural supports can mitigate present or future symptoms.”

Magellan created these *Utilization Management Guidelines* for the Iowa Plan to employ in its efforts to improve the quality of care for members while promoting community-based services. These guidelines encourage providers to select services and levels/sites of care only after carefully assessing the needs of the individual member. It is Magellan’s belief that the use of an appropriate level/site of care will optimize clinical outcome.

Authority

The Iowa Plan for Behavioral Health Utilization Management Guidelines undergo annual review for enhancements and consistency in addressing the psychosocial necessity of members. These updates allow for intervention management changes as increasingly diverse services are developed.

Magellan engages multiple stakeholders to ensure a comprehensive review as well as to foster coordination of resources. The parties involved may include the Clinical Advisory Committees, providers, members, family members, advocacy groups, concomitant service payers—such as DHS Child Welfare, Counties—and Department of Human Services field staff. Magellan will incorporate the input from such resources for review by an advisory committee that constitutes stakeholder representatives.

The development and final approval of the *Utilization Management Guidelines* incorporates the Department of Human Services, Iowa Department of Public Health and the Magellan Corporate Quality Improvement Committee through their representative's attendance at the Iowa Plan Clinical Advisory Committee and the Iowa Plan Quality Improvement Committee.

Final Approval by Clinical Advisory Committee occurred 10/14/09 and by the Quality Improvement Committee on 10/21/09. Any subsequent revisions will be identified with the approval date within the modified section.

Magellan's Clinical Care Management Philosophy

The right service at the right time. The right clinical service early in the process can prevent future loss of functioning.

Magellan's care management philosophy is based on the following priorities:

- Safety and containment when imminent danger is present.
- An emphasis on the immediate motive for seeking help: "Why Now?"
- Careful biopsychosocial assessment to identify the member's needs for acute and continuing (rehabilitative and relapse prevention) interventions.
- Member and family choice.
- Treatment that builds on the member's strengths, adaptive capacities, and resources.
- Services that are tailored to the impairments requiring attention.
- Preference for the least restrictive level/site of care consistent with member needs.
- Preference for the member to remain in the community whenever possible.
- History of previous treatment, services, and their impact.
- Unique circumstances particular to the member.

To apply these guidelines appropriately, the practitioner must consider the comprehensive assessment, services being provided concurrently by other service systems, and special circumstances that have an impact on the availability or accessibility of services. In other words, Magellan bases authorizations for mental health and substance related services on a comprehensive, individualized, holistic, and culturally sensitive approach. Our care management process supports not only authorization for services, but it also considers how other services and supports such as community groups, self-help organizations, and natural supports can help the member meet his or her goals.

Serving a Diverse Population

Diversity is a fact of life for Magellan and our providers. The Iowa Plan serves a wide range of ethnic and social groups, and each member has specific and unique needs that we consider in determining a level/site of care. Additionally, we make every effort to be sensitive to the distinct problems and needs of varying age groups and to respect the cultural and ethnic diversity, as well as the member's choice of provider or treatment location. Magellan encourages our staff and provider community to continue to develop culturally competent attitudes and beliefs, knowledge, and skills. Culturally skilled professionals should attend to, as well as work to, eliminate biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions, and they should develop sensitivity to issues of oppression, sexism, heterosexism, elitism, and racism.¹ Mental health and substance related problems need to be defined and assessed in their cultural context.

¹ Arredondo, P., Toporek, M.S., Brown, S., Jones, J., Locke, D.C., Sanchez, J. and Stadler, H. (1996). Operationalization of the Multicultural Counseling Competencies. AMCD: Alexandria, VA

Diagnosis/Level of Care Explained

The diagnosis of a mental or substance related disorder generally lacks specificity and involves overlap. There are no laboratory tests to diagnose most disorders. Although drug screens may document the presence of a drug, they cannot predict physiological addiction, behavior, or prognosis. Knowing that a member suffers from a disorder may be useful in determining the need for treatment, but diagnosis alone is not sufficient to determine which treatment is best.

Magellan's care management philosophy places emphasis on individualized, focused, service planning. A matrix, found in Appendix A of the *Patient Placement Criteria for the Treatment of Substance-related Disorders (2nd edition-revised)*, published by the American Society of Addiction Medicine, matches severity and needed services along six independent dimensions. Providers and care managers can use this matrix as an aid in determining the optimal level/site of care and mix of necessary services.

Magellan designed our utilization management guidelines to support providers who are innovative in providing services to meet member needs in the most appropriate manner in their homes and communities. We believe that individualized treatment, which draws selectively upon a matrix of service options, will be the hallmark of success in future health care systems.

In keeping with the model described above, Magellan based the definitions for the levels/sites of care on structural characteristics rather than on service, program, or provider characteristics. There are five structural elements:

- Qualification of psychiatric, behavioral health, and addictions treatment staff.
- Level of safety and security.
- Availability and accessibility of therapeutic/treatment resources.
- Degree of self-care required.
- Availability of medical-surgical support and clinical services.

Members may receive treatment services of varying intensities in virtually any setting or level/site of care; therefore, the mode or intensity of treatment is not the sole determinant of placement. Magellan recognizes five major groups of levels/sites of care: inpatient, subacute, residential, intensive outpatient, community-based outpatient, and recovery/resiliency. These categories are not necessarily hierarchical, and a sequential step up or down from one to another should not be presumed. Similarly, these categories are not engaged in a singular fashion, recognizing that a member may need simultaneous levels/sites, such as residential and outpatient. Rather, in keeping with our philosophy, we believe that the provider should match the level/site of care with the member's needs as those needs change and evolve. The level/site of care criteria are meant to complement rather than substitute for clinical judgment. In order to support these principles, we assure—through our policies and procedures—that treating clinicians have access to peer support and review as needed.

How to Use These Guidelines

Magellan designed Sections I through III of these guidelines for use in a coordinated fashion. Based on the clinical assessment outlined in Section I, we expect that the evaluator will arrive at a formulation that encompasses the member's own presenting motive ("Why now?"), significant objective findings from the comprehensive assessment ("What now?"), and risk status. Such a formulation involves a clinical hypothesis that implies what must be done to help the member. In order to transform the formulation into a service plan, it is necessary to identify:

- Which services are necessary and at what intensity.
- Who will provide the services.
- Where is the most appropriate place to provide the services.

The practitioner or care manager must base this determination on the member's overall state of health, including the psychosocial resources available for promoting recovery and the obstacles to such recovery. Section I also includes a matrix for matching the member's health status with services and service intensity. It serves as a guide for seeking authorization.

Determination is a process that may involve the provider and the Magellan care manager at the point of entry, and then repeatedly through the episode of care. We present a glossary of potential, available services and interventions in Section III, while we direct the practitioner and care manager to Section II in order to determine the best match between necessary services and the various levels/sites of care at which they may be offered.

Section I: Member-Driven Treatment Planning Guidelines

The Clinical Process

Magellan’s care managers address two core areas during the process of matching the member with the appropriate level of care:

- a. The member’s and family’s views of current needs and strengths, problem-solving, coping skills and level of functioning as demonstrated through outcomes measurement to maximize the ability to build on these and use appropriate services and natural supports.
- b. A determination of the most appropriate and least restrictive environment and level of service to assure safety and provide the opportunity for recovery and resiliency.

Assessment

This section provides details about Magellan’s service planning guidelines, which are the basis for our care management process. We hope that by understanding the sequence presented, our providers will find our care management process collegial and helpful.

The following are the elements of the assessment process used in developing a targeted service plan:^{2,3}

- Imminence and Severity of Risk
- “Why Now?” the Proximal Cause of the Member’s Request for Help
- “What Now?” The Comprehensive (Biopsychosocial) Assessment
- Care Formulation and the Determination of Necessary Services
- Co-Occurring Matrix for the Determination of Necessary Services and Intensity.

Imminence and Severity of Risk

A fundamental task of the clinical evaluation is to assess risk with regard to its imminence and severity. A clinician should conduct a suicide assessment on any new member who meets criteria for a mental or substance related disorder based upon the current Diagnostic and Statistical Manual of Mental Disorders, or any member who has any other identified potential risk factors. Members with psychiatric disorders have significantly higher rates of suicide attempts when compared to the general community—29 percent compared to 5 percent.⁴ The risk is severe if the member is likely to come to irreversible physical or psychological harm unless action is taken, and it is imminent if the prospect of such harm is impending, requiring immediate action. Risk assessment is an ongoing component of treatment, and it is not limited to the initial evaluation. Initial and continuous risk assessment will shape treatment and determine the need for containment.

Containment should not be equated with inpatient care. Containment for specific clinical circumstances also can occur in a structured living situation, at home with 24-hour supervision, in crisis or respite units, in a nursing home, or with family or friends. Legal requirements to warn

² Bennett, M.J. (1989) The catalytic function in psychotherapy. *Psychiatry*, 52, 351-364.

³ Cummings, N., & Sayama, M. (1995) *Focused psychotherapy*. New York: Brunner/Mazel.

⁴ Oquendo, MA. Prospective Study of Clinical Predictors of Suicidal Acts After a Major Depressive Episode in Patients with Major Depressive Disorder or Bipolar Disorder. *Am J Psychiatry* 2004; 161:1433-1441.

potential victims of violence, pharmacotherapy, and psychotherapy all may be regarded as a form of containment.⁵

The reliability of clinical information depends on how the clinician asks appropriate questions. If the clinician implies overtly or covertly that questions about risk are trivial, an obligation, or a chore to appease a third party, the member may be induced to collude. This can result in the member's denial of imminent risk when it is present. Similarly, a clinician's expectation that the risk is monumental may foster an expectation of dysfunction and dependency, while implying a need for containment only via an inpatient setting.

The effectiveness or ineffectiveness of questions seems to depend on their timing as well as on the appropriateness of the type of question for the task of the interviewer at any specific moment.⁶ The following questions may be helpful in assessing imminent risk, but they are not meant to be an exhaustive list:

- Is severe and imminent risk present because of the prospect of self-harm? Examples include the following:
 - a. A specific suicide plan with intent.
 - b. Command auditory hallucinations involving specific self-harm.
- Is severe and imminent risk to others present as a product of a mental or substance related disorder? Examples include the following:
 - a. Danger to others because of acute manic excitement with grandiosity, such as driving a car at high speed through a congested area without regard for safety.
 - b. Danger to others because of paranoid delusion, such as a member planning to kill the president because he or she believes the president is a foreign spy.
- Does the member have auditory hallucinations commanding the murder of family members, and does the member feel a need to act on such commands?
- Is severe and imminent risk present due to an acute inability to care for self? Examples can include the following:
 - a. Paranoid delusions such as the member believing the food is poisoned, has not eaten or drunk in two days and is dehydrated.
 - b. Acute manic excitement, such as the member being in imminent danger of incurring catastrophic financial losses as a result of grandiose delusions.
- Is severe and imminent risk present as the result of a substance use? An example could include full withdrawal syndrome with a history of delirium tremens.
- Are there withdrawal seizures? If the member's liver compromised, a relapse could result in death.
- Is severe and imminent risk present as the result of life-threatening, complicating medical factors related to a required psychiatric treatment?

⁵ Tarasoff (v.) Regents of the University of California, 17 Cal 3d 425, 551 P2d 334 131 Cal Rptr. 14 (1976).

⁶ Shea, S.C.,(1998) Psychiatric Interviewing, The Art of Understanding. Philadelphia: WB Saunders.

“Why Now?” The Proximal Cause of the Member’s Request for Help

The essence of the “Why now?” is a full understanding of the member’s perspective, in terms of his or her definition of the problem and methods to improve the situation. Members come to the attention of a mental health or addictions treatment professional because they, or someone in their lives, are seeking a solution to an immediate problem, or because they feel distressed. The key to understanding a member’s goals and what is expected from the professional is to know what prompted the request for help at the precise time that the member chose to make contact. This is termed the “operational diagnosis,” which is the answer to the question, “Why now?”

As the proximal cause of the member’s decision to seek help, the “Why now?” must be distinguished from the familiar concept of *precipitant*. If the precipitant is the event that initiated distress or produced destabilization—the first “domino to fall”—such an event usually sets in motion a sequence of responses, such as attempts to adapt, mobilize resources, compensate, and re-establish balance. The “Why now?” often can be found in the failure or absence of such efforts, thus creating a subjective state of distress unique to the member. It may be a response to the last in a series of events—the “straw that broke the camel’s back”—or it may be the meaning that the member attaches to precipitating events or stressors. In those instances where the identified member presents because of the distress or concern of a third party, the “Why now?” must be extracted from the dynamics of their relationships. Sometimes this can be accomplished best through joint or family interviewing.

Not only does the “Why now?” contain the member’s unique distress and motive for seeking help, but it also contains the member’s expectations and attitudes toward changing. For these reasons, attempts to probe and understand the precise timing of the member’s decision to seek help have important implications for structuring treatment, fostering an alliance, developing a focus, and using time and resources efficiently. In constructing the road map of intervention, the “Why now?” is the point of departure for taking the therapeutic journey.

For the Provider/Therapist—Eliciting the “Why now?” from the Member

As with any form of history-taking, a combination of specific questions and an empathic understanding of the subjective state of distress are the keys to understanding why the member is there and what the member is seeking. Specific questions to ask may include the following:

- What brings you into treatment now, rather than one week or one month ago?
- What were you thinking at the precise moment you picked up the phone and called for an appointment?
- I assume you were in distress when you decided to ask for help; what was the distress that you were experiencing at that time?
- What failed you—what stopped working, fell apart, broke, or changed?
- What one thing, if changed, could decrease your distress at this time?

Questions for members who present because someone brought or sent them, or insisted that they seek help could include the following:

- I assume that help has been recommended to you before; why did you choose to go along with it this time?

For Magellan Care Managers—Helping the Therapist Elicit the “Why Now?”

- You have identified an event—set of circumstances, precipitant. What was the uniquely painful meaning of this event—set of circumstances—for this member?
- What prompted the member to seek help in dealing with it at this time? The member chose to come for help at this time, rather than at some other time. What failed—what changed, stopped working, broke?
- It takes courage—motivation, energy—to pick up the phone and ask for help. What drove this member to take the risk at this time?

Table 1—Sample Precipitants and Possible “Why Now?”

Precipitating Event or Circumstance	“Why Now?”
I have a drinking problem.	I got a DUI—and fear going to jail. My spouse is threatening to leave me—and I am afraid that he or she will leave.
I have been depressed since my father/mother died six months ago.	I had unending thoughts of suicide today—and I no longer feel in control. I couldn't get out of bed this morning—and I am afraid of losing my job.
Our daughter skips school, steals money from my purse, and breaks house rules; we can't take it anymore.	I hit her today—and now I fear I am turning into my abusive father/mother.

Case Examples

Case 1: Rejected, But by Whom?

A 22-year-old single woman is seen after being medically cleared in the emergency room after overdosing. The precipitant appears to be a boyfriend of six months breaking up with her. Since there was a 24-hour gap between the precipitant and the overdose, further examination is indicated. The member's response to questioning, regarding the events that occurred between the break-up and the attempted suicide, reveals that she experienced the unavailability of friends and the rejection of her mother. She reports phoning her mother, who, after hearing of the break-up, responded that the member was “a whore who slept with every boy in town,” and that she had gotten what she deserved. The member overdosed within a half hour of this conversation.

The “Why now?” in this case is the rejection by her mother in response to her attempt to adapt to the loss of her boyfriend. Her reaction to her mother's rejection is based on the dynamics of their relationship, underscored by the recent interaction.

The distinction between the precipitating event and the “Why now?” has importance in structuring the therapeutic intervention. Since her behavior indicates that she can cope—she sought support—an appropriate plan is to help her locate available psychosocial support. Through conversation, the member identifies a supportive friend. The friend agrees to come and take her home, stay with her that night, and then bring her to an outpatient appointment the following day. The member agrees not to call her mother prior to the appointment. In the treatment that follows, the therapist is alerted to the member's wish for “the supportive parent I never had” and is able to avoid creating undue dependence by encouraging the member to draw upon appropriate alternative supports in her life.

Case II: Displaced

A 37-year-old man was released from his sheltered-work employment. He becomes increasingly depressed, and six months later, he walks into an emergency room stating that he wants to kill himself. He is admitted to a psychiatric unit and started on antidepressant medication. The assumption is made that his suicidality is a function of reactive depression, subsequent to his job loss. His behaviors, affects, and verbalizations are unremarkable, reassuring staff members, who make no further effort to uncover the “Why now?” On the third day of admission, the member seems to be in better spirits, denies suicidal intent, and is adjusting to the therapeutic milieu. Before retiring that night, he receives a phone call from his mother with whom he lives; later that night, he makes a serious suicide attempt by attempting to hang himself.

Had an effort been made around admission to address the question, “Why did you decide to come to the ER today rather than last week or last month or yesterday,” the staff would have learned that the member’s mother had placed the classified ads on the breakfast table that morning, circled several ads for apartments, and written, “get one of these or else.” On the third day of hospitalization, the mother reiterated her message regarding getting an apartment. The “Why now?” in this case was the mother’s threat, especially, the “or else” part. Had the staff known this, they would have understood his apparent improvement as a sign that the member believed his presence in the hospital protected him from his mother’s threats. They would have been able to address the issue by bringing in the mother and developing a plan to address her concerns without endangering the member.

“What Now?” The Comprehensive (Biopsychosocial) Assessment

Magellan views psychiatric and substance related disorders as biopsychosocial conditions that, to varying degrees, may have biological, medical, psychological, and socio-cultural origins. A problem-driven intervention may take as its point of departure the member’s reason for coming to treatment at that time, but the process of assessment must proceed beyond the problem—or life dilemma—to a complete picture of the person with the problem. If the operational diagnosis is the answer to the question “Why now?” (what brings the member?), the next step, “What now?” addresses the question, “What does the member bring?” (strengths, resources, pathology).

The answer to this second question lies partially in the formal diagnosis, which is a necessary but insufficient determinant of optimal intervention. In order to maximize the use of resources, a broader picture of the member must drive care and care management. Just as a diagnosis of cancer, hypertension, or diabetes calls for clarity with regard to severity and capability for self-management, a thorough assessment of the biological, psychological, and social factors that constitute the member’s milieu or context provides the essential three-dimensional picture of the person with the problem.

Such understanding involves not only the reason(s) for the member’s presenting distress, but it also involves an inventory of the resources and limiting factors that are unique to the member and that will either facilitate or impede efforts to mitigate that distress through some form of corrective action or necessary change. Consideration of the impact of past treatment and service interventions is imperative in this process. The comprehensive assessment should identify those factors that will contribute to or serve as obstacles to the member’s clinical improvement.

Only by linking the member’s subjective experience of distress (“Why now?”) with the assessed parameters of biopsychosocial function (“What now?”) can the therapist engage the member in

the task of identifying and committing to necessary change and agreeing on the focus of intervention. The next step in the process is the development of a formulation and plan of care.

Care Formulation and the Determination of Necessary Services

Care Formulation: Identifying Treatment Needs

Care formulation is the integration of data on the member's motive for seeking help at the time ("Why now?") with his or her risk status (severity and imminence of risk) and resources and impairments ("What now?") in order to understand what must be done. This understanding can be fashioned into a coherent plan of actions by analyzing data and testing hypotheses about the balance between factors that promote or impede the member's recovery. Such plans help to:

- Determine what the member wants.
- Optimize care in the least restrictive setting.
- Optimize selection of providers.
- Involve family and natural supports.
- Identify strengths.
- Improve recovery and resiliency skills by improving feeling of self-control/competency⁷.
- Assist the member/family leads with the planning of goals.

The care plan is not static—it evolves through the episode of care. A longitudinal perspective on restoring health must take into account not only the resolution of acute symptoms and psychosocial needs, but it also must consider the member's prospects for continuing and maintaining progress well. For example, a young adult member with schizophrenia may respond to treatment, but then repeatedly discontinue medication and regress. In order to alter the pattern of relapse and promote recovery, the patterns need to be discussed and barriers to treatment identified. Unless the member has a legitimate choice, treatment will not be sustained.

Co-Occurring Matrix for the Determination of Necessary Services and Intensity

A Model for Co-Occurring Assessment/Service Planning

In the treatment of mental health and substance related disorders, severity generally has been considered the key to placement. Severity usually is attributed globally, by emphasizing the member's early development or trauma(s), diagnosis, previous behavior, impact of previous interventions, or prominent features of the acute presentation—for example, suicidality or withdrawal symptoms. In consequence, decisions about the necessary treatment, including placement at a given site or level of care, may be based on generic principles rather than on a careful matching of resources to the needs of the particular member. Severity ratings also characteristically emphasize the member's pathology while overlooking or underestimating his or her strengths and resources and the importance of context. It is Magellan's practice to consider service intensity, as opposed to illness severity, as a more holistic approach to treatment. Service

⁷ Escape from Babel, Miller/Duncan & Hubble, 1997, W.W. Norton & Co. What works in treatment? Treatment should enhance or highlight the client's feeling of personal control.

intensity, in turn, is determined by considering the member's overall state of health as a gradient that implies service need. The variables to consider are:

- The specific dimension of health status being considered.
- The evidence drawn from the biopsychosocial assessment.
- The relative balance of impairments and strengths.
- The member's previously attained functioning.
- The member's life context (including relationship with helpers).
- The past history of adaptation and treatment responsiveness.
- Accessibility to services.
- The member's choice of provider or service location.

In order to guide the clinician in service planning, a matrix is provided for the selection of necessary services, arranged as a gradient from 0—no immediate services needed—through 4—high intensity of services needed immediately. This matrix:

- Is multi-dimensional, using the six assessment dimensions of the American Society of Addiction Medicine (ASAM), *The ASAM Criteria, 3rd Edition*. Provides benchmarks for intensity of necessary services to assist clinicians and care managers in communicating more effectively in decisions about authorization.
- Promotes individualized treatment by matching the intensity of necessary services in each assessment dimension with the most effective, efficient, and individualized modalities and services.
- Assists—in conjunction with the second section of this manual—in making decisions about level/site of care.

Table 2 outlines the dimensions used to assist in determining service priorities.

Table 2—Dimensions Used to Determine Service Priorities	
Dimension 1 ⁸	Acute intoxication and/or withdrawal potential
Dimension 2	Biomedical conditions and complications
Dimension 3	Emotional/behavioral or cognitive conditions and complications
Dimension 4	Readiness to change
Dimension 5	Relapse/Continued use or continued problem potential
Dimension 6	Recovery/Living environment

Tables three through eight show matrices for matching health status with intensity of necessary services for each dimension.

⁸The assessment dimensions make explicit the components of a biopsychosocial assessment. While Dimension 1, substance use/intoxication/withdrawal, may not apply to all members, there are a sufficient number of members with coexisting mental health and substance use disorders to warrant active consideration of substance use (and intoxication/withdrawal) in any assessment. Additionally, even for members who are not “dually diagnosed,” consideration of a substance-induced disorder (Dimension 1) is important to rule in or out. Developing a multi-dimensional service intensity profile integrates all of the biopsychosocial data, current and past history into a succinct summary. The service intensity profile refers to a rating of each of the assessment dimensions so as to focus more specifically on the major problems and priorities, especially the obstacles to necessary change, while identifying the member’s strengths and resources. Each rating indicates how concerned clinicians and other involved in the member’s care need to be about the dimension under consideration. Treatment priorities indicate the necessary services/modalities as a gradient of intensities. It is incumbent on the provider of care, in conjunction with the provider of authorization, to select the level/site of care that will most effectively and efficiently allow the member to receive those services. An increasing array of available services, modalities and settings, described in Section III, allows for specificity of matching to member needs.

Matrix for Matching Health Status with Intensity of Necessary Services

Table 3—Dimension 1—Acute Intoxication and/or Withdrawal Potential

Health Status: Resources and Obstacles to Member Improvement	Types of Services/Modalities Needed (Refer to Section III to select the combination of services needed in the Service plan)	Intensity of Service Need
Full functioning, with good ability to tolerate and cope with withdrawal discomfort; no signs or symptoms of a substance use problem, intoxication or withdrawal, or resolving signs of symptoms of intoxication or withdrawal	No immediate substance related disorder services, intoxication monitoring, or detoxification services needed	0
Adequate ability to tolerate and cope with substance use problems or withdrawal discomfort; few, if any, substance use problems present; mild to moderate signs or symptoms interfering with daily functioning; minimal risk of severe withdrawal (e.g., as continuing detox from other levels of detox service, or heavy alcohol, sedative, or hypnotic use with minimal seizure risk)	Low intensity of substance related disorder services, intoxication monitoring, or detoxification service needed	1
Poor ability to tolerate and cope with substance use problems or withdrawal discomfort; moderate signs or symptoms, with moderate risk of severe withdrawal (e.g., as continuing detox from other levels of detox service; heavy alcohol, sedative, or hypnotic use with minimal seizure risk; heavy alcohol, sedative, or hypnotic use; or many opiate or stimulant withdrawal signs or symptoms)	Moderate intensity of substance related disorder services, intoxication monitoring, or detoxification services needed	2
Unable to tolerate and cope with substance use problems or withdrawal discomfort; severe signs and symptoms; severe withdrawal and unstable (e.g., as continuing detox from other levels of detox service; excessive doses of sedatives or hypnotic with risk of seizures)	Moderately high intensity of substance related disorder services, intoxication monitoring, or detoxification services needed	3
Incapacitated, with severe substance use problems, signs, and symptoms; severe withdrawal and danger (e.g., experiencing seizures; continuing use is immediately life-threatening from liver failure, GI bleeding, or fetal death)	High intensity of substance related disorder services or intoxication monitoring or detoxification services needed	4

Table 4—Dimension 2—Biomedical Conditions and Complications

Health Status: Resources and Obstacles to Member Improvement	Types of Services/Modalities Needed (Refer to Section III to select the combination of services needed in the Service plan)	Intensity of Service Need
Full functioning, with good ability to cope with physical discomfort; no biomedical signs or symptoms or stable biomedical problems (e.g., stable hypertension, stable chronic pain)	No immediate biomedical services needed	0
Adequate ability to tolerate and cope with physical discomfort; few, if any, biomedical problems; mild to moderate signs or symptoms (e.g., mild to moderate pain interfering with daily functioning; unstable, symptomatic hypertension)	Low intensity of biomedical services	1
Poor ability to tolerate and cope with physical discomfort; few, if any, biomedical problems; mild to moderate signs or symptoms (e.g., mild to moderate pain interfering with daily functioning; unstable, symptomatic hypertension)	Moderate intensity of biomedical services	2
Unable to tolerate and cope with physical problems and/or general health condition poor; severe medical problems present, but stable (e.g., severe pain requiring medication, unstable diabetes)	Moderately high intensity of biomedical services	3
Incapacitated, with severe medical problems, unstable (e.g., extreme pain, uncontrolled diabetes; GI bleeding, IV antibiotics)	High intensity of biomedical services	4

Table 5—Dimension 3—Emotional, Behavioral, or Cognitive Conditions and Complications

Health Status: Resources and Obstacles to Member Improvement	Types of Services/Modalities Needed (Refer to Section III to select the combination of services needed in the Service plan)	Intensity of Service Need
Full functioning, with good resources and skills to cope with emotional problems, and/or no emotional or behavioral problems identified, or are stable (e.g., depression stable on anti-depressants)	No immediate mental health services needed	0
Adequate resources and skills to cope with emotional or behavioral problems, and/or mild to moderate signs or symptoms (e.g., dysphoria, relationship problems/ work or school problems)	Low intensity of mental health services	1
Poor resources with moderate or minimal skills to cope with emotional or behavioral problems; frequent and intensive symptoms (e.g., frequent suicidal or homicidal ideation, vegetative signs, agitation, or retardation, inconsistent impulse control)	Moderate intensity of mental health services	2
Severe lack of resources and skills to cope with emotional or behavioral problems; significant functional impairment, with severe symptoms (e.g., suicidal or homicidal threats or recent serious attempts, disorganized thinking, inadequate ADLs, depression with significant vegetative signs, agitation or retardation, poor impulse control)	Moderately high intensity of mental health services	3
Insufficient or severely limited resources or skills necessary to maintain adequate level of functioning; severe, acute life-threatening symptoms (e.g., dangerous or impulsive behavior or impaired cognitive functioning placing self or others at imminent risk; symptoms of psychosis: hallucinations, delusions; thought disorder with acute onset places self or others at risk; minimal ADLs)	High intensity of mental health services	4

Table 6—Dimension 4—Readiness to Change

Health Status: Resources and Obstacles to Member Improvement	Types of Services/Modalities Needed (Refer to Section III to select the combination of services needed in the Service plan)	Intensity of Service Need
Cooperative, motivated, ready to change	No immediate motivational strategies or services needed.	0
Motivated with active reinforcement; ambivalent about illness or need for change, but willing to explore treatment, and need and strategies for change	Low intensity of motivational strategies with education about illness; education of family, significant others, legal system, work or school to reinforce treatment need.	1
Verbal compliance without consistent behaviors; low motivation for change passively involved in treatment (e.g., with use psychotropic medication, poor monitoring, variable compliance)	Moderate intensity of motivational strategies with active family, significant others, legal work or school systems to set and follow through with clear, consistent limits and consequences.	2
Inconsistent compliance; minimal awareness of illness; minimally cooperative; ambivalence about change results in unwillingness or poor follow-through on treatment recommendations	Moderately high intensity of motivational strategies to try to engage the member in treatment; but most effort focused on any systems leverage (family, school, work, or legal) to align incentives that promote treatment engagement and investment of member; if resistance is troublesome due to psychosis, IM injections of depot anti-psychotic may be necessary.	3
Non-compliant or dangerously oppositional; no awareness of illness; not wanting or willing to explore change; total denial of illness and its implications (e.g., member is convinced of being poisoned and rejects medication and other treatment; member blames others for legal or family problems, and rejects treatment	Containment, if imminently dangerous; but individual motivational strategies unlikely to be useful; focus on any systems leverage (family, school, work, or legal) to align incentives that promote treatment engagement and investment of member; if resistance dangerous due to psychosis, secure unit and involuntary commitment may be necessary.	4

Table 7—Dimension 5—Relapse, Continued Use or Continued Problem Potential

Health Status: Resources and Obstacles to Member Improvement	Types of Services/Modalities Needed (Refer to Section III to select the combination of services needed in the Service plan)	Intensity of Service Need
No relapse potential; or low potential with good coping skills	No immediate relapse prevention services needed; may need self/mutual help or non-professional support group	0
Relapse potential minimal, with some vulnerability; fair self-management and relapse prevention skills	Low intensity relapse prevention services to reinforce coping skills until integrated into aftercare, self/mutual help, or non-professional group	1
Poor recognition and understanding of relapse issues; able to self-manage with prompting	Moderate intensity of relapse prevention services to monitor and strengthen coping skills; relapse prevention education; consider anti-craving medications; integration into self/mutual help and community support services	2
Little recognition and understanding of relapse issues; poor skills to cope and interrupt psychological or addiction problems, or to avoid or limit a relapse	Moderately high intensity of relapse prevention services; structured coping skills training; motivational strategies; explore family or significant others' ability to align incentives to consolidate engagement in treatment; consider containment if imminently dangerous	3
Repeated treatment episodes with no positive impact on functioning; no coping skills to manage psychological or addiction illness, or prevent relapse	Containment if imminently dangerous; explore family or significant others' ability to align incentives to consolidate engagement in treatment; motivational strategies; structured coping skills remaining	4

Table 8—Dimension 6—Recovery/Living Environment

Health Status: Resources and Obstacles to Member Improvement	Types of Services/Modalities Needed (Refer to Section III to select the combination of services needed in the Service plan)	Intensity of Service Need
Supportive environment, or member is able to cope with poor supports	No immediate supportive living or skills training services needed	0
Passive support or significant others are not interested; member not too distracted by this and able to cope	Low intensity of supportive living or skills training services	1
Unsupportive environment, but with clinical structure, member can cope most of the time	Moderate intensity of supportive living or skills training services	2
Supports are absent, or poor; member finds coping difficult, even with clinical structure	Moderately high intensity of supportive living or skills training services, depending on member's coping skills and impulse control	3
Unsupportive and actively hostile environment that is toxic to recovery or treatment progress	High intensity of supportive living or skills training services, depending on member's coping skills, impulse control, and/or need for protection	4

Case Examples

Case I: Problems at Home

A 16-year-old woman is brought into the emergency room of an acute care hospital, which has an inpatient psychiatric unit. She had argued with her parents over her present choice of boyfriends and ended up throwing a chair. There was some indication that she was intoxicated at the time, and her parents have been concerned about her coming home late and mixing with the wrong crowd. There has been considerable family discord, mutual anger, and frustration between the teen and especially her father. There has been no previous treatment.

The parents are both present in the emergency room, but the young woman was brought in by the police, who had been called by her mother. The emergency room physicians and nurse from the psychiatric unit, who came to evaluate the teen, all feel she needs to be in the hospital, given the animosity at home, the violent behavior, and the question of intoxication. Using the matrix for determining service needs and intensity, they set about preparing their clinical data to seek authorization. They assess her service needs and service intensity profile as follows:

Table 9—Case I: Problems at Home

Dimension 1—Acute Intoxication and/or Withdrawal Potential	
Intensity of Service Rating 0— Though intoxicated at home not long before the chair-throwing incident, she no longer is intoxicated and has not been using alcohol or other drugs in quantities large or long enough to suggest any withdrawal danger	Services Needed— No specific service needed
Dimension 2—Biomedical Conditions and Complications	
Intensity of Service Rating 0 – She is not on any medications, has been physically healthy, and has no current complaints	Services Needed— No specific service needed
Dimension 3—Emotional, Behavioral, Cognitive Conditions and Complications	
Intensity of Services Rating 2— Complex problems with anger, frustration, and family discord; history of chair throwing, but is not impulsive at present if separated from her parents	Services Needed— Intensive outpatient services, but not in acute danger of harm to self or others if away from parents, at least for the first night
Dimension 4—Readiness for Change	
Intensity of Services Rating 1— Willing to talk to the therapist; blames her parents for being overbearing and not trusting her; agrees to come into treatment, but doesn't want to be at home at least for tonight	Services Needed— Motivational strategies to engage member in looking at her behavior, to get sufficient education to check on any substance-related illness, and to negotiate with her parents

Dimension 5—Relapse, Continued Use, or Continued Problem Potential

Intensity of Services Rating 3—

High likelihood of a recurrence of the fighting and possible violence if released to go back home immediately

Services Needed—

Coping skills training and motivational strategies to engage in family therapy to resolve family discord and prepare for return to home situation if possible

Dimension 6—Recovery/Living Environment

Intensity of Services Rating 3—

Parents frustrated and angry, mistrustful of member, and want her in the hospital to cut down on the family fighting.

Services Needed—

Support living environment tonight to separate teen from parents until the situation is less volatile, to allow time for family session when all are calmer, and to clarify under what circumstances the teen will return home; parents want to work it out, but are tired and frustrated

Level/Site of Care

Upon completion of the service intensity profile, it becomes clear to the psychiatric nurse and emergency room physician that the teen does not need an acute care hospital, but that she needs placement, at least for the night, to separate her from her parents. Such placement might include a stay with other family members or at a youth shelter. The girl and her family also need to begin outpatient treatment. Further evaluation is needed in a family session to determine if the time apart from the parents only is needed on a short-term basis until the immediate anger and frustration have subsided. Outpatient family treatment is arranged immediately, and a discussion follows in order to determine the best arrangement for the night.

Case II: Drinking and Driving

A 23-year old single female, the mother of a toddler, was advised by her lawyer to present herself for treatment since it would “look good” when appearing in court for her third drinking and driving violation. She is presenting for treatment of her own volition. She denies any prior mental health services, but she describes intermittent depressive symptoms since adolescence and at present.

She started using alcohol at age 16 on weekends and at parties, and during her senior year in high school, she began drinking more frequently. She has experimented with cocaine and marijuana, but alcohol remains her drug of choice, with some daily use and heavy weekend use. She stopped on her own for about one month after her last car accident.

The woman faces court charges and the possibility of a court-mandated program and admits that her drinking and driving is dangerous. Five years ago, she had eight weeks of DUI classes, and she had a weekend of inpatient treatment in the past. She has attended two court-mandated Alcoholics Anonymous (AA) meetings, but she felt she was not as bad as the others there. She plans to attend AA only if mandated.

Using the matrix for the determination of service needs and intensity, the counselor evaluates the clinical data to help determine the individualized service plan and optimal level/site of care. The service intensity profile is developed as follows:

Table 10—Case II: Drinking and Driving

Dimension 1—Acute Intoxication and/or Withdrawal Potential	
<p>Intensity of Service Rating 0—</p> <p>Last use: Alcohol—12 beers on the day prior to the evaluation; no previous detox or severe withdrawal; BP 100/70; pulse 94; temperature 98; breathalyzer on evaluation 0.03 g/100ml; in no distress; alert, oriented, with no tremor; skin warm and dry; nothing to suggest any severe withdrawal danger</p>	<p>Services Needed—</p> <p>Member agrees to call back in 4 hours, or earlier, if necessary, to report on any symptoms of withdrawal; otherwise, no specific service needed; substance use is problematic, but the provision of services must await motivational work (Dimensions -4)</p>
Dimension 2—Biomedical Conditions and Complications	
<p>Intensity of Service Rating 0 –</p> <p>No physical complaints; not on any medications and has been physically healthy</p>	<p>Services Needed—</p> <p>No specific service needed</p>
Dimension 3—Emotional, Behavioral, Cognitive Conditions and Complications	
<p>Intensity of Services Rating 2—</p> <p>Depressive symptoms at present and reports of similar symptoms in past prior to substance related onset; some anxiety about court appearance, but mental status screening unremarkable; no previous psychiatric history</p>	<p>Services Needed—</p> <p>Psychiatric assessment to consider pharmacotherapy and differential diagnosis</p>
Dimension 4—Readiness for Change	
<p>Intensity of Services Rating 3—</p> <p>Mainly presenting for treatment to look good for court, but does admit to some problems; willing to be involved in treatment, but likely to comply only if court-coerced, not because of “internal” distress</p>	<p>Services Needed—</p> <p>Motivational strategies to see if member can move from external pressure to internal investment in recovery; family work with parents necessary to explore leverage since member lives with them; contact with lawyer to define consequences if member’s drinking and driving continues; individual and group work to discern impact of drinking on her parenting</p>
Dimension 5—Relapse, Continued Use, or Continued Problem Potential	
<p>Intensity of Services Rating 3—</p> <p>Poor skills to consistently avoid further drinking problems, but sufficiently concerned about court appearance to control immediate drinking</p>	<p>Services Needed—</p> <p>Motivational strategies to engage member in recognizing her lack of coping skills to prevent further drinking problems and to see if she can</p>

behavior; not imminently dangerous to self or others	invest in outpatient substance related treatment and AA or other self-help support groups; random urine or breathalyzer tests to provide external structure and demonstrate to member to what degree she can prevent drinking
Dimension 6—Recovery/Living Environment	
Intensity of Services Rating 1— Court issues are a stressor, but also an asset to provide leverage to help engage member in examining her drinking and behavior; parents are helping pay for some of member’s legal fees; they are angry and frustrated with her, but willing to participate in sessions to explore limit setting and discern transportation/child care issues	Services Needed— Contact with lawyer to clarify legal situation; family education and session to evaluate potential for motivating leverage, since they partially support member; member is able to stay at home as long as she participates in treatment

Level/Site of Care

There are no imminently dangerous Dimensions 1-3 priorities needing containment or 24-hour medical/nursing care. Outpatient treatment is required to implement the motivational strategies needed to try to engage and convert the member into internally directed recovery. In light of the suspicion of a depressive disorder, a psychiatric assessment is coordinated via the primary counselor to ensure follow through. Using the external legal and family pressures, the member may be helped to expand on her beginning recognition that there might be a drinking problem.

The initial plan is for random urine/breathalyzer; psychiatric assessment, and follow-up visit(s), while undergoing substance related treatment; twice weekly group therapy and educational sessions to monitor and examine the member’s perhaps overconfident plan that her will power will provide all the help she needs to prevent continued use and problems; and family education and sessions to promote limit-setting. This can be achieved in less than nine hours per week of outpatient service. If the member demonstrates the failure of her “will power” plan, and her impulse control dangerously worsens, more intensive treatment may become necessary. Otherwise, the service plan is modified and other outpatient and self-mutual help modalities are added to address her Dimension 4 and 5 priorities.

Case III: Self-Injurious Behavior

A 10-year-old male with severe mental retardation engages in high rates of self-injury, both at home and at school. Phone interviews with parents and teachers indicate that self-injury—such as biting his arm and slapping his face—occurs frequently whenever he is required to perform a non-preferred task, such as brushing his teeth or completing academic tasks. Aggression, such as biting and head-butting, occurs when self-injury is blocked. Self-injury and aggression rarely occur when he is playing or left alone. Both his parents and the school staff report that the severity of these behaviors has resulted in them placing decreased demands on him, which has significantly interfered with his development of adaptive behavior. Self-injury has been occurring for at least six years, but it recently has increased in frequency and severity.

The child’s parents and teachers accompanied him to an outpatient clinic for evaluation and treatment on two occasions, during which functional behavior analyses were conducted. The results supported interview data, indicating that self-injury served as an “escape” function—negative reinforcement—and rarely occurred during any other environmental condition. Thus, it occurred only when non-preferred demands were being made on the boy. Aggression occurred only if self-injury was blocked. Both self-injury and aggression caused tissue damage, and both stopped almost immediately when demands were discontinued.

The parents and teachers attempted to treat these behaviors, first on their own, and then with the assistance of in-home service providers and support staff from the Area Education Agency. They reported that they had no success with treatments recommended through outpatient services and that they had “lost their confidence.” Changes in both home and school placements were not being considered, with long-term residential placement or institutionalization being the most likely options. The following service intensity profile was developed.

Table 11—Case III: Self-Injurious Behavior

Dimension 1—Acute Intoxication and/or Withdrawal Potential	
Intensity of Service Rating 0— No use of alcohol or drugs	Services Needed— No specific services needed
Dimension 2—Biomedical Conditions and Complications	
Intensity of Service Rating 2 – Undetermined whether child's self-injury is a maladaptive response to pain or whether child does not respond to pain; in either case, pain does not cause child to avoid self-injury; child cannot carry out activities required for daily living without self-injury, which causes tissue damage and could lead to severe medical problems such as secondary to infection from biting	Services Needed— Continued analysis to determine relationship of pain to self-injury; continued assessment must be carried out in a setting in which tissue damage can be evaluated and, if necessary, controlled

Dimension 3—Emotional, Behavioral, Cognitive Conditions and Complications

Intensity of Services Rating 4—

Child cannot carry out even those activities of daily living that would be expected from a person with severe mental retardation, due to his inability to deal adaptively with routine, normal demands; self-injurious behavior causes tissue damage; frequent aggression is present, with potential for serious injury to others; a complex hierarchy of aberrant behavior is occurring that precludes growth in child's adaptive behavior

Services Needed—

Intensive service beyond those already provided to develop adaptive responses (such as communication) to demand situations, while preventing injury to child and others

Dimension 4—Readiness for Change

Intensity of Services Rating 4—

Child has no awareness of condition and no willingness to change; family, while supportive, no longer has confidence in the recommended treatments and will not implement them at this time

Services Needed—

Intensive evaluation of etiology and maintenance of aberrant behaviors, including biologic variables; development and intensive implementation of functional communication training to replace self-injury with adaptive communicative responses

Dimension 5—Relapse, Continued Use, or Continued Problem Potential

Intensity of Services Rating 4—

There have been repeated treatment episodes in outpatient settings; these have been unsuccessful even with the availability of support from school staff; there is no likelihood that treatment will be successful without intensive evaluation and implementation in an inpatient setting

Services Needed—

Inpatient intensive evaluation and treatment, followed by training of parents and school and community support staff

Dimension 6—Recovery/Living Environment

Intensity of Services Rating 3—

Although family and school staff are supportive, they are no longer willing to carry out treatment recommendations that have been ineffective; no other treatment services of sufficient intensity and quality are available in the home community.; unless changes occur quickly, there is a high probability of long-term, out-of-home placement

Services Needed—

Following the development of an effective service plan, training is needed for the family and school staff; this training needs to include observation of successful treatment followed by implementation staff; ongoing treatment will be needed, with implementation of treatment strategies by family and community support staff

Level/Site of Care

Following a review of the service needs matrix, it appears that a relatively brief inpatient admission to an appropriate facility is needed to provide sufficient treatment intensity, given the inability of the prior outpatient services to produce significant behavior change.

A typical admission for the identified problems might include the following components:

- a. Identify which variables, including biologic, are having an impact on the behaviors.
- b. Develop and implement a service plan involving functional communication training to replace self-injury and aggression with appropriate communicative responses.
- c. Train parents and teachers in these procedures.

Outpatient follow-up and ongoing treatment by parents, teachers, and community support staff would help to ensure that the service plan is implemented and modified as needed.

Conclusion

This concludes Section I of the *Iowa Plan for Behavioral Health Utilization Management Guidelines*, which Magellan designed to support informed clinical decision-making. We offer the recommendations contained in Section I as suggestions to enhance clarity of communication and facilitate the authorization process. We have provided the actual details regarding authorization, denials, appeals, and other relevant policies and procedures in provider manuals. They will vary depending on the nature of the member's health insurance contract.

It is our expectation that the practitioner will use Magellan's guidelines to complement rather than substitute for clinical judgment. Based on a thorough assessment of clinical need, as illustrated in Section I, the practitioners should carefully consider service options such as those described in Section III of this manual, and then match them to the appropriate settings, as described in Section II. This matching should occur not once, but as often as necessary throughout an episode of care. Magellan will endeavor to enhance such matching by periodically updating our list of services and levels/sites of care as continuing advances in the treatment of mental health and substance related disorders occur.

Glossary of Terms

The definitions that follow are designed solely to assist the reader in understanding Section I of these guidelines; they may not coincide with contract-specific language in some cases.

Clinical stability—determined by the member’s degree of lethality to self or others, emotional stability, integrity of cognitive capacities, ability to perform activities of daily living, and current medical/surgical condition.

Co-occurring—members present for care with active symptoms of both mental health and substance related disorders.

Containment—an activity or function designed to create a safe environment for the welfare of the member and others, based on the identification of clinical risk. Containment is not defined by a structure, such as a locked care unit, but rather by the activities and functions of monitoring, treatment interventions, and removing or controlling environmental hazards that may jeopardize the immediate safety of the member or others.

Cultural competency—a set of knowledge, skills, attitudes, policies, practices, and methods that enable care providers and programs to work effectively with culturally diverse members, families, and communities. Culturally competent behavioral health care providers have, at a minimum, linguistic competence and also some knowledge about the culture and ethnicity. They also should have the knowledge and skills to use assessment and treatment methods that are appropriate for multi-cultural members.

Determination—the decision-making process by which the formulation is fashioned into a plan of corrective action, involving choice of necessary services, intensity of services, providers(s), and level/site of care. By involving the clinician with the agent of authorization—usually the care manager—determination takes place both at the point of entry into the health care system and periodically through the episode of care.

Family driven—families have a primary decision-making role in the care of their own children, as well as in the policies and procedures governing care for all children in their community, state, tribe, territory, and nation.

Formulation—the hypothesis produced by a multi-dimensional assessment of member needs that specifies the objectives of treatment and links the member’s subjective sense of distress with objective findings. Depending on the orientation of the evaluator, formulation may be expressed in behavioral, psychodynamic, or cognitive terms, or a mix of these. Formulation implies a plan of intervention designed to achieve necessary change.

Functional impairment—the extent to which a mental health or substance related disorder impairs the member’s capacity to maintain activities of daily living, interpersonal relationships, and/or vocational/educational activities.

Imminent risk—the highest priority of member needs, calling for immediate containment in order to prevent harm to self or others.

Level/site of care—an environment characterized by specific structural and staffing components that supports the provision of mental health and substance related disorder treatment. The level/site of care may vary as the member’s needs evolve through an episode of care.

Recovery—all people living with behavioral health conditions have the capacity to learn, grow, and change, and they can achieve a life filled with meaning and purpose.

Resiliency—all people have qualities that enable them to rebound from adversity, trauma, tragedy, threats, or other stresses, and to go on with life with a sense of mastery, competence, and hope.

What Now?—addresses what the member brings, such as strengths, resources, and pathology.

Why Now?—the operational diagnosis; the proximal cause of the member’s decision to seek help (treatment) at the precise time that he or she chooses to make contact. Recognition of this “motive” will help identify the member’s treatment expectations as well as the specific causes of the member’s destabilization. The operational diagnosis is central to identifying the focus of intervention treatment.

Section II: Recovery Driven Levels of Care

Inpatient Services

Hospitalization, Psychiatric Adult

Description

Inpatient hospitalization, the most restrictive and intrusive level of care, allows for interventions requiring high frequency and intensity of application and 24-hour professional management, supervision, and treatment. Hospitalization provides a high degree of assurance of safety and services of a high level of intensity.

Twenty-four hour inpatient hospitalization also provides on-site medical and nursing care for members at risk because of medical/surgical disorders that may affect—or be affected by—procedures necessary to treat a mental health or substance related disorder.

Services are provided 24 hours per day, 7 days per week, in an appropriately licensed facility. Treatment focuses on reducing immediate risk of danger to self or others, severe disability, or medical factors associated with a mental health disorder that place the member at significant risk. The member's treatment should reflect consideration of historical factors including trials of maximal utilization of service intensity via lower levels of care and other delivery systems. Treatment is intensive and is provided in a secure environment by a multi-disciplinary team of qualified professionals, including nursing personnel.

An example of inpatient facility is a hospital with a locked inpatient unit.

Service Components (must meet all of the following)

1. Multi-disciplinary professional staff must include the following:
 - a. Board-eligible or board-certified psychiatrist.
 - b. Registered nurses.
 - c. Psychologists, social workers, and ancillary staff available when clinically indicated.
2. A psychiatrist must see and evaluate the member within 24 hours of admission and see the member daily, including weekends, thereafter.
3. The attending psychiatrist will prepare an individualized, documented, service plan directed toward the alleviation of the impairment(s) that caused the admission within 48 hours of admission, including weekends.
4. The family and all active pre-hospitalization caregivers, including mental health and addiction treatment professionals and primary care physicians, will have immediate involvement in the evaluation, service planning activities, and treatment as appropriate.
5. A thoroughly documented treatment record (see Appendix A for details).
6. Active discharge planning must be initiated at time of admission to program and culminate in a comprehensive discharge plan.
7. Appropriate medical services must be available.
8. Active treatment must focus on stabilizing or reversing symptoms necessitating admission and developing services/supports to maintain functioning improvement.

9. Service plan updates will reflect the member's progress and/or new information that become available—including, but not exclusive to, appropriate changes in somatic therapies where lack of progress persists.
10. Nurses, therapists, and physicians complete daily assessments and active interventions based on the comprehensive service plan.
11. The utilization management staff, if used, must convey accurate, up-to-date information about the member's status and treatment, as documented in the medical record.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis and must meet at least one of the following criteria:

1. Presents a danger to self, as a product of the principal DSM-5 diagnosis, as evidenced by any of the following:
 - a. attempts to harm self that are life-threatening or could cause disabling permanent damage with continued imminent risk,
 - b. Current, specific plan to harm self with clear intention, high lethality, and availability of means.
 - c. A level of suicidality that cannot be managed safely at a less restrictive level of care.
 - d. Suicidality accompanied by rejection or lack of available social/therapeutic support.
2. Presents a danger to others, as a product of the principal DSM-5 diagnosis, as evidenced by any of the following:
 - a. Life-threatening action with continued imminent risk.
 - b. Current, specific plan with clear intention, high lethality, and availability of means.
 - c. Dangerousness accompanied by a rejection or lack of available social/therapeutic support.
3. Exhibits behaviors/symptoms that historically have been prodromes of harm to self/others; services/supports to avert the need for acute hospitalization are not available via coordination efforts.
4. Exhibits an acute inability to care for self, secondary to a mental health disorder that is accompanied by gaps in psychosocial resources that would restore and/or maintain self care.
5. Requires inpatient medical supervision for the treatment of a mental health disorder because of life-threatening, complicating medical factors.
6. Meets one of the following admission factors for a primary diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified:
 - a. Body weight that is less than 75 percent of the ideal body weight or a body mass index that is 16 or below.
 - b. Weight loss of more than 15 percent in one month.
 - c. Weight loss associated with physiologic instability unexplained by any other medical condition.
 - d. Rapid approach of a weight at which physiologic instability occurred in the past.

Continued Treatment Criteria

The member must have a valid DSM-5 diagnosis that remains the principal diagnosis and must meet 1, 2, and either 3 or 4 of the following criteria:

1. There is a reasonable likelihood of a substantial benefit as a result of medical intervention that necessitates the 24-hour inpatient care setting.
2. The member and family, if appropriate, are making progress toward the goals and actively are participating in the intervention.
3. Symptoms or behaviors and a lack of psychosocial resources that required admission continue, and the judgment is that a less intensive level of care would be insufficient to stabilize the member's condition.
4. New impairments meeting admission guidelines appear.

Hospitalization, Psychiatric, Child and Adolescent

Description

Inpatient hospitalization, the most restrictive and intrusive level of care, allows for interventions requiring high frequency and intensity of application and 24-hour professional management, supervision, and treatment. Hospitalization provides a high degree of assurance of safety and services of a high level of intensity.

Twenty-four hour inpatient hospitalization also provides on-site medical and nursing care for members at risk because of medical/surgical disorders that may affect—or be affected by—procedures necessary to treat a mental health or substance related disorder.

Services are provided 24 hours per day, 7 days per week, in an appropriately licensed facility. Treatment focuses on reducing immediate risk of danger to self or others, severe disability, or medical factors associated with a mental health disorder that place the member at significant risk. The member's treatment should reflect consideration of historical factors including trials of maximal utilization of service intensity via lower levels of care and other delivery systems. Treatment is intensive and is provided in a secure environment by a multi-disciplinary team of qualified professionals, including nursing personnel. Services are dedicated specifically to the child/adolescent population and secluded from adult members. School services are available.

An example of an inpatient facility is a hospital locked inpatient unit.

Service Components (must meet all of the following)

1. Multi-disciplinary professional staff must include the following:
 - a. Board-eligible or board-certified psychiatrist.
 - b. Registered nurses.
 - c. Psychologists, social workers, and ancillary staff available when clinically indicated.
2. A psychiatrist must see and evaluate the member within 24 hours of admission and see the member daily, including weekends, thereafter.
3. The attending psychiatrist will prepare an individualized, documented, service plan directed toward the alleviation of the impairment(s) that caused the admission within 48 hours of admission, including weekends.
4. The family and all active pre-hospitalization caregivers, including mental health and addiction treatment professionals and primary care physicians, will have immediate involvement in evaluation, service planning activities, and in treatment as appropriate.
5. A thoroughly documented treatment record (see Appendix A for details).
6. Active discharge planning must be initiated at time of admission to program and culminate in a comprehensive discharge plan.
7. Appropriate medical services must be available.
8. Active treatment must focus on stabilizing or reversing symptoms necessitating admission and developing services/supports to maintain functioning improvement.

9. Service plan updates will reflect the member's progress and/or new information that has become available—including, but not exclusive to, appropriate changes in somatic therapies where lack of progress persists.
10. Nurses, therapists, and physicians complete daily assessments and active interventions based on the comprehensive service plan.
11. The utilization management staff, if used, must convey accurate, up-to-date information about the member's status and treatment, as documented in the medical record.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis and at least one of the following:

1. Presents a danger to self, as a product of the principal DSM-5 diagnosis, as evidenced by any of the following:
 - a. Attempts to harm self that are life-threatening or could cause disabling permanent damage with continued imminent risk.
 - b. Current, specific plan to harm self with clear intention, high lethality, and availability of means.
 - c. A level of suicidality that cannot be managed safely at a less restrictive level of care.
 - d. Suicidality accompanied by rejection or lack of available social/therapeutic support.
2. Presents a danger to others, as a product of the principal DSM-5 diagnosis, as evidenced by any of the following:
 - a. Life-threatening action with continued imminent risk.
 - b. Current, specific plan with clear intention, high lethality, and availability of means.
 - c. Dangerousness accompanied by a rejection or lack of available social/therapeutic support.
3. Exhibits behaviors/symptoms that historically have been prodromes of harm to self/others and services/supports to avert the need for acute hospitalization are not available via coordination efforts.
4. Exhibits an acute inability to care for self, secondary to a mental health disorder that is accompanied by gaps in psychosocial resources that would restore and/or maintain self care.
5. Requires inpatient medical supervision for the treatment of a mental health disorder because of life-threatening, complicating medical factors.
6. Meets one of the following admission factors for a primary diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating Disorder Not Otherwise Specified:
 - a. Body weight that is less than 75 percent of the ideal body weight, or a body mass index that is 16 or below.
 - b. Weight loss of more than 15 percent in one month.
 - c. Weight loss associated with physiologic instability unexplained by any other medical condition.
 - d. Rapid approach of a weight at which physiologic instability occurred in the past.
 - e. Body weight of less than 85 percent of the ideal body weight during a period of rapid growth.

Continued Treatment Criteria

The member must have a valid DSM-5 diagnosis that remains the principal diagnosis and meet 1, 2, and either 3 or 4 of the following criteria:

1. There is a reasonable likelihood of substantial benefit as a result of medical intervention that necessitates the 24-hour inpatient care setting.
2. The member and family, if appropriate, are making progress toward goals and actively are participating in the intervention.
3. Symptoms or behaviors and lack of psychosocial resources that required admission continue, and the judgment is that a less intensive level of care would be insufficient to stabilize the member's condition.
4. New impairments meeting admission guidelines appear.

Hospitalization, Psychiatric, Geriatric

Description

Inpatient hospitalization, the most restrictive and intrusive level of care, allows for interventions requiring high frequency and intensity of application and 24-hour professional management, supervision, and treatment. Hospitalization provides a high degree of assurance of safety and services of a high level of intensity.

Twenty-four hour inpatient hospitalization also provides on-site medical and nursing care for members at risk because of medical/surgical disorders that may affect—or be affected by—procedures necessary to treat a mental health or substance related disorder.

Services are provided 24 hours per day, 7 days per week, in an appropriately licensed facility. Treatment focuses on reducing immediate risk of danger to self or others, severe disability, or medical factors associated with a mental health disorder that place the member at significant risk. The member's treatment should reflect consideration of historical factors including trials of maximal utilization of service intensity via lower levels of care and other delivery systems. Treatment is intensive and is provided in a secure environment by a multi-disciplinary team of qualified professionals, including nursing personnel. Staff with specific training in geriatric acute services is available. A dedicated unit or area for this group is preferred in order to provide optimal treatment.

An example of an inpatient facility is a hospital locked inpatient unit.

Service Components (must meet all of the following)

1. Multi-disciplinary professional staff must include the following:
 - a. Board-eligible or board-certified psychiatrist.
 - b. Registered nurses.
 - c. Psychologists, social workers, and ancillary staff available when clinically indicated.
2. A psychiatrist must see and evaluate the member within 24 hours of admission, and see the member daily, including weekends, thereafter.
3. The attending psychiatrist will prepare an individualized, documented, service plan directed toward the alleviation of the impairment(s) that caused the admission within 48 hours of admission, including weekends.
4. Immediate involvement of family and all active pre-hospitalization caregivers, including mental health and addiction treatment professionals and primary care physicians, in evaluation, service planning activities, and in treatment as appropriate.
5. A thoroughly documented treatment record (see Appendix A for details).
6. Active discharge planning must be initiated at time of admission to program and culminate in a comprehensive discharge plan (see discharge criteria #2).
7. Appropriate medical services must be available.
8. Active treatment must focus on stabilizing or reversing symptoms necessitating admission and developing services/supports to maintain functioning improvement.

9. Service plan updates will reflect the member's progress and/or new information that has become available—including, but not exclusive to, appropriate changes in somatic therapies where lack of progress persists.
10. Nurses, therapists, and physicians complete daily assessments and active interventions based on the comprehensive service plan.
11. The utilization management staff, if used, must convey accurate, up-to-date information about member's status and treatment, as documented in the medical record.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis and at least one of the following:

1. Presents danger to self, as a product of the principal DSM-5 diagnosis, as evidenced by any of the following:
 - a. Attempts to harm self that are life-threatening or could cause disabling permanent damage with continued imminent risk.
 - b. Current, specific plan to harm self with clear intention, high lethality, and availability of means.
 - c. A level of suicidality that cannot be managed safely at a less restrictive level of care.
 - d. Suicidality accompanied by rejection or lack of available social/therapeutic support.
2. Presents a danger to others, as a product of the principal DSM-5 diagnosis, as evidenced by any of the following:
 - a. Life-threatening action with continued imminent risk.
 - b. Current, specific plan with clear intention, high lethality, and availability of means.
 - c. Dangerousness accompanied by a rejection or lack of available social/therapeutic support.
3. Exhibits behaviors/symptoms that historically have been prodromes of harm to self/others and services/supports to avert the need for acute hospitalization are not available via coordination efforts.
4. Exhibits acute inability to care for self, secondary to a mental health disorder that is accompanied by gaps in psychosocial resources that would restore and/or maintain self care.
5. Requires inpatient medical supervision for the treatment of a mental health disorder because of life-threatening, complicating medical factors.
6. Meets one of the following admission criteria for a primary diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating Disorder Not Otherwise Specified:
 - a. Body weight that is less than 75 of the ideal body weight, or a body mass index that is 16 or below.
 - b. Weight loss of more than 15 percent in one month.
 - c. Weight loss associated with physiologic instability unexplained by any other medical condition.
 - d. Rapid approach of a weight at which physiologic instability occurred in the past.

Continued Treatment Criteria

The member must have a valid DSM-5 diagnosis that remains the principal diagnosis meet 1, 2, and either 3 or 4 of the following criteria:

1. There must be a reasonable likelihood of substantial benefit as a result of medical intervention that necessitates the 24-hour inpatient care setting.
2. The member and family, if appropriate, are making progress toward the goals and actively are participating in the intervention.
3. Symptoms or behaviors and lack of psychosocial resources that required admission continue, and the judgment is that a less intensive level of care would be insufficient to stabilize the member's condition.
4. New impairments meeting admission guidelines appear.

Twenty-Three Hour Crisis Observation, Evaluation, and Stabilization

Description

This level of care provides up to 23 hours and 59 minutes of care in a secure and protected, medically staffed, psychiatrically supervised, treatment environment. This can include continuous nursing services and an on-site or on-call psychiatrist. The primary objective is the prompt evaluation and/or stabilization of members presenting with acute psychiatric symptoms or distress. This level of care may be used for a comprehensive assessment and to obtain classification regarding previously incomplete patient information that may lead to a determination that the member requires a more intensive level of care.

This service is not appropriate for individuals who, by history or initial clinical presentation, require services of an acute care setting exceeding 23 hours and 59 minutes. Duration of services at this level of care may not exceed these hours, by which time stabilization and/or determination of the appropriate level of care will be made, and the treatment team will coordinate the facilitation of appropriate treatment and support linkages.

Service Components (Must meet all of the following)

1. Multi-disciplinary professional staff must include the following:
 - a. Board-eligible or board-certified psychiatrist.
 - b. Registered nurses.
 - c. Psychologists, social workers, and ancillary staff available when clinically indicated.
2. The attending psychiatrist will prepare an individualized, documented, service plan directed toward crisis intervention services necessary to stabilize and restore the member to a level of functioning that does not require hospitalization.
3. The family and all active pre-hospitalization caregivers, including mental health and addiction treatment professionals and primary care physicians, will have immediate involvement in evaluation, service planning activities, and treatment as appropriate.
4. Active discharge planning must begin at the time of admission to the 23 hour bed and culminate in a comprehensive discharge plan (see discharge criteria #2).
5. Appropriate medical services must be available.
6. The utilization management staff, if used, must convey accurate, up-to-date information about the member's status and treatment, as documented in the medical record.

Admission Criteria

The member must have a valid DSM-5 diagnosis that remains the principal diagnosis and meet all of the following criteria:

1. There must be indications that the symptoms may stabilize and an alternative treatment may be initiated within a 23 hour, 59 minute period.
2. The resending crisis cannot be safely evaluated or managed in a less restrictive setting, or, the member could be safely evaluated and managed in a less restrictive setting, but such a setting is not immediately available.
3. There is an indication of actual or potential danger to self as evidenced by suicidal intent or a recent attempt with continued intent as evidenced by the circumstances of the attempt, the member's statements, or intense feelings of hopelessness and helplessness.
4. In addition to the above, at least *one* of the following must be present.
 - a. Command auditory/visual hallucinations or delusions leading to suicidal or homicidal intent.
 - b. An indication of actual or potential danger to others as evidenced by a current threat.
 - c. Loss of impulse control leading to life-threatening behavior and/or other psychiatric symptoms that require immediate stabilization in a structured psychiatrically monitored setting.
 - d. substance related and mental health symptoms—intoxication, agitation, depressed, suicidal or homicidal ideation
 - e. The member is experiencing a crisis demonstrated by an abrupt or substantial change in normal life functioning brought on by a specific cause, sudden event, and/or severe stressor.
 - f. The member demonstrates a significant incapacitating or debilitating disturbance in mood and/or thought that interferes with ADLs wherein the observation period will allow for evaluation and planned interventions via less intensive services.

Continued Treatment Criteria

There is no continued stay associated with 23-hour, 59-minute observation. The member must transfer to a more/less intensive level of care.

Lateral Transfer Guidelines

One of the following guidelines must be met for lateral transfer:

1. Specialty services required for the patient are not available at the present facility, and the facility has made a concerted effort in conjunction with Magellan to facilitate the availability of the services within the present facility. This may be accomplished via expert consultation, either by telephone or on-site.
2. There is diagnostic dilemma wherein an absolute diagnosis is essential at the immediate time so as to foster life-saving interventions—for example, a highly suicidal patient who may be refractory and/or refusing all services at the present facility, so that a diagnostic clarification may not be available at present facility.
3. The member fails to progress in treatment, wherein maximum engagement of a variety of modalities have ensued or been considered or engaged before a lateral transfer to another facility.
4. The member has had multiple readmissions to the present facility, and a new facility may enhance treatment planning by fostering a new therapeutic relationship.
5. A new facility may be able to engage a wider array of services/interventions that may optimize treatment/discharge planning.
6. An adverse clinical situation at the present facility—such as allegations of abuse—causes Magellan to actively pursue another facility.

Subacute Services

Traditional Inpatient Subacute

Description

Subacute services, although less restrictive than inpatient, provide for interventions requiring high frequency and intensity of application, as well as 24-hour management, supervision, and treatment. There is a high degree of assurance of safety, but a locked unit is not necessary or required for provision of on-site services.

Subacute inpatient services also have the potential for on-site medical and nursing care for persons at risk because of medical/surgical disorders that may affect—or be affected by—procedures necessary to treat a mental health disorder.

Services are provided 24 hours per day, 7 days per week, in an appropriately licensed facility. Treatment focuses on reducing immediate risk of danger to self or others, severe disability, or medical factors associated with a mental health disorder that place the person at significant risk. The member's treatment should reflect consideration of historical factors including trials of maximal utilization of service in intensity via lower levels of care and other delivery systems. Treatment is intensive and is provided in a secure environment by a multi-disciplinary team of qualified professionals, including nursing personnel.

Examples of traditional Inpatient Subacute facilities include the following:

- Hospital locked inpatient unit.
- Hospital open inpatient unit.
- Specified licensed ICF/PMI.
- PMIC.

Service components (must meet all of the following)

1. Multi-disciplinary professional staff must include the following:
 - a. Board-eligible or board-certified psychiatrist.
 - b. Registered nurses.
 - c. Psychologists, social workers, and ancillary staff available when clinically indicated.
2. An independently licensed mental health professional must see and evaluate the member at admission, and see the member every 24 hours thereafter.
3. The family and all active pre-hospitalization caregivers, including addiction treatment professionals and primary care physicians, will have immediate involvement in evaluation, service planning activities, and treatment as appropriate.
4. Evaluation/consultation by a board-eligible or board-certified psychiatrist must be available every 72 hours from admission or more as clinically indicated.
5. An individualized plan of active psychiatric treatment must be completed within 48 hours of admission, including weekends. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan must include all of the following:
 - a. At least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not appropriate or feasible.

- b. Psychotropic medication to be used with specific target symptoms identified.
 - c. Evaluation for current medical problems.
 - d. Evaluation for concomitant substance use issues.
 - e. Linkage and/or coordination with the member's community resources, with the goal of returning the member to his or her regular social environment as soon as possible, unless contraindicated.
6. Active discharge planning must begin at the time of admission to the program and culminate in a comprehensive discharge plan.
 7. Active treatment focuses on stabilizing or reversing symptoms necessitating admission and developing services/supports to maintain functioning improvement.
 8. Service plan updates reflect the person's progress and/or new information that has become available—including but not exclusive to appropriate changes in somatic therapies where lack of progress persists.
 9. The utilization management staff, if used, must convey accurate, up-to-date information about the member's status and treatment as documented in the medical report.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis and meet all of the following:

1. There is clinical evidence that the member has a DSM-5 disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization without intervention.
2. Due to the psychiatric disorder, the member exhibits an inability to adequately care for his or her own physical needs, representing potential serious harm to self and/or others.
3. The person requires 24-hour supervision to develop skills necessary for daily living, to assist with planning and arranging access to a range of education, therapeutic and after-care services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

Continued Treatment Criteria

The member must have a valid DSM-5 diagnosis that remains the principal diagnosis and meet all of the following:

1. Despite reasonable therapeutic efforts, the clinical evidence indicates at least one of the following:
 - a. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria.
 - b. The emergence of additional problems that meet the admission criteria.
 - c. Disposition planning and/or attempts at therapeutic re-entry into the community have resulted in—or would result in—exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.
2. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems.

Crisis Stabilization

Description

Crisis Stabilization provides a professional response where members in urgent/emergency need can receive crisis stabilization services. It provides continuous 24-hour observation and supervision for members who do not require intensive clinical treatment in an inpatient psychiatric setting and would benefit from a short-term, structured stabilization setting. Services at this level of care—which may or not be provided in a medical setting—include crisis stabilization, initial and continuing bio-psychosocial assessment, care management, medication management, and mobilization of family support and community resources.

The primary objective of Crisis Stabilization is to promptly conduct a comprehensive assessment of the member and to develop a treatment plan with an emphasis on the crisis intervention services necessary to stabilize and restore the member to a level of functioning that requires a less restrictive level of care. Duration of services should not exceed 72 hours, by which time a determination of the appropriate level of care will be made, and the treatment team will coordinate facilitation of appropriate linkages.

Service Components (must meet all of the following)

1. A safe environment with a provider who has a state certification or national health accreditation for 24 hour mental health crisis stabilization services.
2. The member must be evaluated by an independently licensed mental health professional at admission and at discharge.
3. Evaluation/consultation by a board-eligible or board-certified psychiatrist must be available as clinically indicated. The member's psychiatrist or other physician should approve of admission.
4. There must be immediate involvement of family and all active pre-hospitalization caregivers, including addiction treatment professionals and primary care physicians, in evaluation, service planning activities, and treatment as appropriate.
5. An individualized plan of active psychiatric treatment must be completed within 48 hours of admission, including weekends. This plan must include all of the following:
 - a. Family and/or support system involvement, unless there is an identified, valid reason why it is not appropriate or feasible.
 - b. Psychotropic medication to be used with specific target symptoms identified.
 - c. Evaluation for concomitant substance use issues.
 - d. Linkage and/or coordination with the member's community resources, with the goal of returning the member to his or her regular social environment as soon as possible, unless contraindicated.
6. The provision of discharge planning that would include appropriate follow up by appropriate mental health/substance related providers.
7. Transfer of the member to an appropriate inpatient psychiatric facility when risk factors are identified outside the treatment area of the Crisis Stabilization bed. This would include the following:

- a. Suicidal/homicidal ideation/intent with access and means.
- b. Pervasive psychosis with severe functioning impairment.
- c. Severe mania with impairment in functioning that could not be managed by the Crisis Stabilization provider.
- d. Medical issues requiring a more intensive level of care.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis and meet at least one of the following criteria:

1. Must demonstrate a significant incapacitating or debilitating disturbance in mood/thought interfering with ADLs to the extent that immediate stabilization is required.
2. The clinical evaluation of the member's condition must indicate a sudden decompensation with a potential for danger—but not imminently dangerous—to self or others, and the member has no available supports to provide continuous monitoring.
3. The member requires 24 hour observation and supervision, but not the constant observation of an inpatient psychiatric setting.
4. The clinical evaluation indicates the member can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame.

Continued Treatment Criteria

The member must have a valid DSM-5 diagnosis that remains the principal diagnosis. Despite reasonable therapeutic efforts, the clinical evidence indicates at least one of the following:

1. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria.
2. The emergence of additional problems that meet the admission criteria.
3. The disposition planning and/or attempts at therapeutic re-entry into the community have resulted in—or would result in—exacerbation of the psychiatric illness to the degree that would necessitate continued crisis residential treatment.
4. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems.

In/Out of Home Respite

Description

In/out-of-home Respite services are community and home-based services that can be provided in a variety of settings. Respite care is a brief period of rest and support for members and/or their families. It is intended to provide a safe environment with staff assistance for members who lack an adequate support system to address current problems/issues related to a mental health diagnosis. Respite may be provided for up to 72 hours; it either is planned or provided in response to a crisis.

A comprehensive respite program must provide or ensure linkages to a variety of residential alternatives for stabilizing and maintaining members who require short-term respite in a safe, secure environment, with 24-hour supervision outside a hospital setting. This community-based alternative to inpatient hospitalization provides a temporary, safe, and secure environment with a flexible level of supervision and structure. Services divert members from an acute hospitalization to a safe environment where monitoring of medical and psychiatric symptoms can occur. Respite services may include any of the types of programs described below.

Examples of out-of-home Respite include the following:

- Shelters.
- PMIC.
- Respite homes.

Examples of in-home Respite include the following:

- In-home respite providers.
- Peer specialist.

Service Components (must meet all of the following)

1. The respite provider must have access to an independent licensed mental health practitioner or board-eligible or board-certified psychiatrist, 24 hours a day, 7 days a week; the member's psychiatrist or other physician must approve the service.
2. Respite staff receives basic training in mental health symptoms, emergency response training, and in crisis identification and response procedures.
3. There must be the ability to coordinate with other providers regarding the treatment and discharge planning of members in respite care.
4. There must be continuous documentation of the member's activities/progress and any case management activities while the member is in respite care.
5. There must be immediate access to local hospital/emergency care.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis and meet all of the following criteria:

1. The member must be at risk of a crisis for acute psychiatric symptoms—but he or she is not a threat to him or herself or others.

2. The member's family and caregivers are unable to participate in the normal activities of daily life in a community as a result of caring for the member, thus putting the member at risk for out-of-home placement.
3. The member gives voluntary consent to participate in respite services.

Continuing Stay Criteria

Because respite care is a time limited service, continuing stay criteria does not apply.

Residential Services

Section 1.01

Psychiatric Medical Institutions for Children (PMIC) – Mental Health/Substance Related

Description

A Psychiatric Medical Institution for Children (PMIC) is a non-secure institution that provides 24 hours of continuous care and diagnostic or long-term psychiatric services to children (under age 21). All PMICs – which provide mental health and substance related services – must be licensed by the state of Iowa as a PMIC, and they must utilize a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of members in accordance with a medical care plan developed for each member. PMICs must provide social and rehabilitative services under the direction of a qualified mental health professional.

Service Components (must meet all of the following)

1. Multi-disciplinary professional staff including:
 - a. Board-eligible or certified psychiatrist.
 - b. Registered nurses.
 - c. Psychologists, social workers, addiction and ancillary staff available when clinically indicated.
2. The individual is sufficiently mentally competent and cognitively stable to benefit from admission.
3. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, under the direction of a licensed physician, with 24-hour medical availability. This plan must include intensive individual, group and family therapy and education in a residential rehabilitative setting. In addition, the plan must include at least weekly therapeutic interventions with family and/or support system, unless there is an identified, valid reason why such a plan is not appropriate or feasible.
4. Service plan is updated to reflect the member's progress and/or new information that have become available.
5. Active discharge planning must be initiated at time of admission to program and culminates in a comprehensive discharge plan. PMIC providers are expected to coordinate discharge services with community providers to ensure a smooth transition back into the community without undue scheduling delays.
6. Active treatment is focused upon stabilizing or reversing symptoms necessitating admission and developing services/supports to maintain functioning improvement.
7. Daily assessments and active interventions are completed by nurses, therapists, and physicians based upon the comprehensive service plan.

Admission Criteria (Must meet one through six)

1. Medical Stability
 - a. The member is medically stable and does not require 24 hour medical/nursing care. If recent substance use is documented or suspected, medical consultation must be sought for an assessment of withdrawal risk.

2. Biomedical Conditions and Complications
 - a. Medical origins of current behavior have received proper assessment. Any treatment recommended from the assessment should be secured for the member.
 - b. Psychotropic medications, when used, are to be used with specific target symptoms identified and be monitored by a psychiatrist. Members should receive psychiatric visits according to need – monthly at a minimum.

3. Emotional /Behavioral Conditions and Complications
 - a. There is clinical evidence that the individual has a DSM-5 disorder that is amendable to active psychiatric treatment. Current symptoms demonstrate an effect on the individual's daily functioning requiring supervision seven days per week/24 hours per day.
 - b. There is a high degree of potential of the condition leading to acute psychiatric hospitalization and/or risk to self or others in the absence of residential treatment.
 - c. As a result of the member's mental health/substance related disorder, there is an inability to adequately care for one's physical needs, and family members/guardians nor services enhancements are able to safely fulfill these needs, representing potential serious harm to self.

4. Treatment Acceptance/Resistance
 - a. The individual's motivation toward mental health/substance related treatment is assessed. An individualized plan will be developed that addresses this level of acceptance/resistance. Those with limited motivation will need a specific engagement strategy towards a therapeutic relationship that is assessed frequently.
 - b. Family members/guardians must be actively involved in order for the member to be successful in treatment and return to a community setting. If family members/guardians are not engaged in treatment, an individualized plan to address these concerns is developed.

5. Relapse/Continued Use Potential
 - a. The individual has experienced episodes of difficulty in controlling substance use or mental health symptoms despite previous professional intervention. As appropriate, the individual has attempted services at a less restrictive setting but has been unable to maintain recovery or safety.
 - b. The individual's mental health/substance related symptoms (i.e. aggression, psychosis, suicidality) and associated behaviors are contributing to a severe disruption of daily functioning.

- i. Family – the individual’s symptoms and associated behavior are contributing to a severe disruption of family life. Family functioning is poor despite professional intervention. The daily disruption is evident through an inability to complete daily tasks, through behavior disruption and through problems establishing a daily routine.
- ii. School - the individual’s academic behavior and school permanency is threatened due to symptoms related to their mental health/substance related disorder. This persists despite efforts from the school and behavioral professionals attempting to stabilize the situation.
- c. Individuals who have previously completed mental health/substance related treatment may need a relapse orientated treatment plan that does not re-address issues that may have been resolved.

6. Recovery Environment

- a. There is evidence of objective, measureable, and time-limited therapeutic clinical goals that must be met before the member can return to a new or previous living situation. The individual and family coping system have attempted to resolve symptoms and functioning problems in conjunction with help from service providers.
- b. Discharge planning will include the enhancement and/or development of a recovery environment that will continue to meet the member’s needs in the community. Discharge planning should not only include professional supports but also natural supports as available, such as AA/NA, mentoring, and other peer supports.

Continued Treatment Criteria

Criteria 1-5 must be met to satisfy the criteria for continued stay.

- 1. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - a. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria *or*
 - b. The emergence of additional problems that meet the admission criteria *or*
 - c. Disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued PMIC treatment.
- 2. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.
- 3. The current or revised treatment plan can be reasonably expected to bring about significant improvement.
- 4. There is evidence of at least weekly therapeutic interventions with family and/or support system, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- 5. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and identifies appropriate treatment resources upon discharge.

Intensive Outpatient Services

Partial Hospitalization

Description

A Partial Hospitalization Program (PHP) is a form of intensive outpatient treatment for mental health disorders that require psychosocial services of a moderate to high level of intensity.

Examples of PHPs include the following:

- Partial hospitalization.
- Partial day treatment.

Service Components (must meet all of the following)

1. The professional staff must meet the following conditions:
 - a. Psychiatric and medical consultation must be readily available.
 - b. A licensed physician who is board-certified or board-eligible in psychiatry, a psychologist, or a licensed independent mental health professional must supervise all services. The psychiatrist must see the member at a minimum of every five treatment days.
 - c. Licensed clinicians must authorize and review services provided by non-licensed clinicians and co-sign the appropriate documentation.
2. The member must have a minimum of five hours of active mental health disorder treatment per day within a structured therapeutic milieu—exclusive of formal education and support groups administered by non-licensed/certified personnel.
3. By the second session, a documented, there must be a thorough diagnostic assessment of the member's mental health and substance use treatment needs, as well as a psychosocial assessment of resources and needs.
4. By the second session, there must be a documented, individualized, comprehensive service plan based on the diagnostic assessment that culminates in a comprehensive discharge plan.
5. By the second session, there must be a documented plan for continued stay need, or the member is discharged to a less restrictive level of care.
6. There must be a thoroughly documented treatment record (see Appendix A for details).
7. There must be evidence of appropriate therapies and coordination of service from other delivery systems, as outlined in the service plan, administered by appropriately qualified, licensed/certified professionals.
8. There must be documented evidence of direct involvement by the family and all active outpatient caregivers and psychosocial resources in service planning and treatment as indicated. Telephonic family conferences may be appropriate when distance or travel time make face-to face sessions impractical. A specific goal of this team is to improve the symptoms and level of functioning enough to return the member to a lesser level of care.
9. A board-certified or board-eligible psychiatrist must be on call 24 hours a day, 7 days a week.

10. A licensed mental health professional must be on call 24 hours a day, 7 days a week for emergencies.
11. The utilization management staff, if used, must convey accurate, up-to-date information about member's status and treatment as documented in the medical record.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis, and all of the following criteria must apply:

1. The member has a diagnosed or suspected mental illness—defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness must be documented through the assignment of appropriate DSM-5 codes on all applicable axes (I-V).
2. There is clinical evidence that the member's condition requires a structured program with frequent nursing and medical supervision, intervention, and/or treatment that cannot be provided in a less intensive outpatient setting at this time, and/or a partial hospital program can safely substitute for, or shorten, a hospital stay.
3. Either of the following must apply—
 - a. There is clinical evidence that the member would be at risk to self or others if he or she were not in a partial hospitalization program, *or*
 - b. As a result of the member's mental disorder, there is an inability to adequately care for his or her physical needs, representing potential serious harm to self.
4. Additionally; either of the following must apply—
 - a. The member can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, *or*
 - b. The member is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.
5. The member is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

Continued Treatment Criteria (must meet all of the following)

1. Despite reasonable therapeutic efforts, the clinical evidence indicates at least one of the following—
 - a. The persistence of problems that caused the admission to a degree continues to meet the admission criteria, *or*
 - b. The emergence of additional problems meet the admission criteria, *or*
 - c. Disposition planning and/or attempts at therapeutic re-entry into the community have resulted in—or would result in—exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.
2. There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.

Intensive Outpatient Program (Mental Health)

Description

Intensive outpatient programs (IOP) are mental health disorder treatment programs that typically meet three or more times per week for a minimum of nine hours weekly. Typically, modalities in such programs include member skills training, group and family therapy, medication management, relapse prevention training, psychoeducation, and coordination of psychosocial resources.

Examples of IOPs include the following:

- Hospital-based intensive outpatient program.
- CMHC-based intensive outpatient program.

Service Components (must meet all of the following)

1. Professional staff must meet the following conditions:
 - a. Psychiatric and medical consultation must be readily available.
 - b. A licensed physician who is board-certified or board-eligible in psychiatry, a psychologist, or a licensed independent mental health professional must supervise all services.
 - c. Licensed clinicians authorize and review services provided by non-licensed clinicians, and they co-sign appropriate documentation.
2. Therapy must include a minimum of nine hours of active mental health/substance related disorder treatment per week within a structured therapeutic milieu (exclusive of formal education and support groups administered by non-licensed/certified personnel).
3. By the second session, the therapist must prepare a documented, thorough diagnostic assessment of the member's mental health, substance related disorder, and psychosocial treatment needs.
4. By the second session, the therapist must prepare a documented, individualized, comprehensive service plan based on the diagnostic assessment that culminates in a comprehensive discharge plan.
5. By the second session, the therapist must prepare a documented plan for the member's discharge to a less restrictive level of care.
6. The therapist must prepare a thoroughly documented treatment record (see Appendix A for details).
7. The therapist must provide evidence of appropriate therapies and coordination of services from other delivery systems, as outlined in the service plan, administered by appropriately qualified, licensed/certified professionals.
8. The therapist must provide documented evidence of direct family involvement and involvement of all active outpatient caregivers and psychosocial resources in service planning and treatment as indicated.
9. A physician—a board-certified or board-eligible psychiatrist—must be on call 24 hours a day, 7 days a week.

10. A licensed mental health professional must be on call 24 hours a day, 7 days a week for emergencies.
11. The utilization management staff, if used, must convey accurate, up-to-date information about member's status and treatment as documented in the medical record.

The member must have a valid principal DSM-5 diagnosis, and meet all of the following:

1. The member is unable to maintain an adequate level of functioning outside the treatment program due to a mental health disorder as evidenced by:
 - a. Severe symptoms.
 - b. Inability to perform the activities of daily living.
 - c. Failure of social/occupational functioning or failure and/or absence of social support resources.
2. The treatment necessary to reverse or stabilize the member's condition requires the frequency, intensity, and duration of contact provided by a day treatment program as evidenced by:
 - a. The failure to reverse/stabilize with less intensive treatment that was accompanied by services of alternative delivery systems.
 - b. The need for a specialized service plan for a specific impairment.
 - c. Passive or active opposition to treatment and the risk of severe adverse consequences if treatment is not pursued.
3. The facility staff can adequately monitor and manage the member's medical and mental health needs.

Continued Treatment Criteria (must meet all of the following)

1. Despite reasonable therapeutic efforts, the clinical evidence indicates at least one of the following:
 - a. The persistence of problems that caused the admission to a degree that continues to meet the admission criteria, *or*
 - b. The emergence of additional problems that meet the admission criteria, *or*
 - c. Disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.
2. There is a reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
3. The member and family (if appropriate) are making progress toward goals and actively participating in the interventions. Children and Adolescents service plans must include at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not appropriate or feasible.

Community Based Outpatient Services

Behavioral Health Intervention Services (BHIS) –

Psychiatric skill/support development

Adults age 18 and over

Description

These intervention services are designed to improve skills associated with the impact of a mental illness. They are always offered as part of a comprehensive clinical treatment plan. Skill development should focus on needed improvement due to an Axis I mental health diagnosis. The improvements should focus on mental health symptoms and improvements in functioning related to the mental illness. The focus of the service should be an individual goal the member has developed to help attain work, school, social or living areas. The focus of intervention is skills and supports needed to reach this goal.

Skills to focus on for improvement include:

- conflict resolution
- problem solving
- social
- interpersonal relationship
- communication
- executive (shifting cognitive set/organization and planning/separating thoughts and emotions)
- language processing (emotional vocabulary)
- emotional regulation
- cognitive flexibility

Service Components (must meet all of the following)

1. An independently-licensed clinician must oversee the services, treatment plan and provide concurrent therapy as indicated. This professional would be licensed in Iowa as a: LISW, LMFT, LMHC, licensed psychologist, physician's assistant, ARNP with mental health certification or a psychiatrist. All clinicians must meet Magellan credentialing standards in Iowa.
2. A treatment plan will be developed, for all behavioral services, identifying problems, action steps, strengths and goals with timeframes for goal attainment.
3. If clinician requesting BHIS is not the current therapist and/or medication management provider, the clinician must coordinate the treatment plan with those providers.
4. The identified clinician will coordinate care with the professional providing medication management, if applicable.
5. A thoroughly documented treatment record (see Appendix A for details).
6. Active discharge planning must be initiated at time of admission to program and culminate in a comprehensive discharge plan.

7. Appropriate other mental health and substance related services and treatment recommendations must be utilized in accordance with the standards of evidenced based practice.
8. Active treatment must focus on stabilizing or reversing symptoms necessitating admission and developing skills to improve and maintain functioning improvement.
9. Treatment plan updates will reflect the member's progress and/or new information that have become available—including, but not exclusive to, appropriate changes in interventions where lack of progress persists.
10. Natural supports and community resources must be considered and engaged as available for skill improvement/development.
11. The identified clinician will coordinate with the child's medical providers.

Admission Criteria (must meet all three)

1. The member must have a valid principal DSM-5 Axis I diagnosis. Recent persistent functional impairments caused by a mental illness must meet at least one of the following:
 - a. Aggressive physical and/or verbal behavior that disrupts the setting in which they occur.
 - b. Depressed mood and/or agitation related to a diagnosis of depression.
 - c. Recent behavior that poses a direct risk to self or others.
 - d. Isolation that results in a persistent impairment in functioning.
 - e. Persistent and validated psychosis that results in a persistent impairment in functioning.
 - f. Obsessive behaviors, as a result of a mental illness, that causes a persistent impairment in functioning.
 - g. Recent changes in social, work/academic, psychological functioning that may be the result of a mental illness.
2. Therapy and/or medication management services have been attempted previously with further functional progress needed as identified by a measured tool. If therapy and/or medication management services have not been attempted previously, there is a valid clinical reason outlined in the assessment.
3. There is reasonable likelihood that the member will benefit from BHIS and there is not a more appropriate service designed to meet the member's needs (i.e. elderly waiver, habilitation, community support services, intensive psychiatric rehabilitation).

Continued Treatment Criteria

The member must have a valid DSM-5 Axis I diagnosis that remains the principal diagnosis, and meet two or more of the following criteria in addition to the admission criteria:

1. The member and family, if appropriate, are making progress toward goals and participating in the intervention. There is progress that requires further treatment to reach a measured level of stable functioning.

2. Symptoms or behaviors that required admission are not significantly responding to the current treatment plan and requires that a revised clinical treatment plan be formulated and implemented.
3. New mental health symptoms and/or impairments that would benefit from specific skill development and meet admission guidelines appear.

Exclusions

Speech/occupational therapy
Music therapy
Equine therapy
Treatment of intellectual disabilities
Educational programming
Services should not interfere with school instruction
Day care
Recreational activities/sports activities
Respite
Group treatment over 10 in members
Multiple groups held in same room
Tracking activity
Observation of behavior
Services provided during transportation
Community outings
Eating out at restaurants
General conversation
Self-care skills
Nonconfidential settings, i.e. school hallways, stairwells, malls
Services must be provided in person

Behavioral Health Intervention Services (BHIS) –

Health and Behavior Intervention (HBI)

Children age twenty (20) and under

Description

These intervention services are designed to improve skills associated with the impact of a mental illness. They are always offered as part of a comprehensive clinical treatment plan. Skill development should focus on needed improvement due to an Axis I mental health diagnosis. The improvements focus on mental health symptoms and improvements in functioning related to the mental illness. Services are delivered face to face in the same location.

Skills to focus on for improvement include:

- conflict resolution
- problem solving
- social
- interpersonal relationship
- communication
- executive (shifting cognitive set/organization and planning/separating thoughts and emotions)
- language processing (emotional vocabulary)
- emotional regulation
- cognitive flexibility

Service Components (must meet all of the following)

1. An appropriately licensed clinician must oversee services (see BHIS Credentialing Standards and Staff Requirements).
2. A treatment plan will be developed, for all behavioral services, identifying problems, action steps, strengths and goals with time frames for goal attainment.
3. If clinician requesting BHIS is not the current therapist and/or medication management provider, the clinician must coordinate the treatment plan with those providers as evidenced by the integration of treatment plan documentation.
4. The identified clinician will coordinate care with the professional providing medication management, if applicable. This will result in the integration of treatment plan documentation.
5. The family and/or identified significant others is engaged and approves of services throughout the treatment process. The family is present for at least 50 percent of the interventions for those services provided in the community. Group homes will involve the family/significant others consistently.
6. Siblings that are involved in treatment simultaneously should have an appropriate combination of shared family and individual interventions.
7. A thoroughly documented treatment record (see Appendix A for details).

8. Active discharge planning must be initiated at time of admission to program and culminate in a comprehensive discharge plan.
9. Appropriate other mental health and substance related services must be considered. Children and families must be presented with all necessary treatment opportunities (e.g. additional mental health or substance related services) and educated about optimal outcomes with implementation and adherence to such options.
10. Active treatment must focus on stabilizing or reversing symptoms necessitating admission and developing skills to improve and maintain functioning improvement.
11. Treatment plan updates will reflect the member's progress and/or new information that has become available—including, but not exclusive to, appropriate changes in interventions where lack of progress persists.
12. Natural supports and community resources must be considered and engaged as available for skill improvement/development.
13. The identified clinician will coordinate with the child's medical providers.
14. Coordination with the clinical treatment plan with identified school staff is required.
15. Communication with the parents/caregivers to reinforce consistent interventions and treatment goals (previously known as family training) will be providing as BHIS family units.

Admission Criteria (must meet all three)

1. The member must have a valid principal DSM-5 Axis I diagnosis. Recent persistent functional impairments caused by a mental illness (must meet at least one of the following):
 - a. Aggressive physical and/or verbal behavior that disrupts the setting in which they occur.
 - b. Depressed mood and/or agitation related to a diagnosis of depression.
 - c. Recent behavior that poses a direct risk to self or others.
 - d. Isolation that results in a persistent impairment in functioning.
 - e. Persistent and validated psychosis that results in a persistent impairment in functioning.
 - f. Obsessive behaviors, as a result of a mental illness, that causes a persistent impairment in functioning.
 - g. Recent changes in social, academic, psychological or family functioning that may be the result of a mental illness.
2. Therapy and/or medication management services have been attempted previously with further functional progress needed as identified by a measured tool. If they have not been attempted previously, there is a valid clinical reason outlined in the assessment.
3. There is reasonable likelihood that the member will benefit from specific skill development services and there is not a more appropriate service and/or evidenced based practice designed to meet the child's needs.

Continued Treatment Criteria

The member must have a valid DSM-5 Axis I diagnosis that remains the principal diagnosis and meet two or more of the following criteria in addition to continuing to meet admission guidelines:

1. There is a reasonable likelihood of benefit as a result of continued intervention based on a current or revised clinical treatment plan.
2. The member and family are making progress toward goals and actively are participating in the intervention. There is progress that requires further treatment to reach a measured level of stable functioning.
3. Symptoms or behaviors that required admission are not significantly responding to the current treatment plan and requires that a revised clinical treatment plan be formulated and implemented.

Exclusions

Speech/occupational therapy

Music therapy

Equine/pet therapy

Treatment of intellectual disabilities

Treatment of neurodevelopmental disabilities

Educational programming

Services should not interfere with school instruction

Day care

Recreational activities/sports activities

Respite

Group treatment over 10 in members

Multiple groups held in same room

Tracking activity

Observation of behavior

Services provided during transportation

Community outings

Eating out at restaurants

General conversation

Self-care skills

Nonconfidential settings, i.e. school hallways, stairwells, malls, parks, restaurants or motor vehicles

Exercise activities

Child welfare needs

Interventions must be in person

Behavioral Health Intervention Services (BHIS) –

Crisis Intervention

Description

These intervention services are designed to respond to symptoms and behaviors associated with the impact of a mental illness. They are always offered as part of a comprehensive clinical treatment plan. Interventions should focus on needed improvement due to an Axis I mental health diagnosis. The improvements should be focused on mental health symptoms and improvements in functioning related to the mental illness. Services are delivered face-to-face in the same location.

Skills to focus on for improvement include:

- conflict resolution
- problem solving
- interpersonal relationship
- communication
- executive (shifting cognitive set/organization and planning/separating thoughts and emotions)
- language processing (emotional vocabulary)
- emotional regulation
- cognitive flexibility

Service Components (must meet all of the following)

1. An appropriately licensed clinician must oversee services (see BHIS Credentialing Standards and Staff Requirements).
2. A crisis plan will be developed as part of the overall treatment plan.
3. If clinician requesting BHIS is not the current therapist and/or medication management provider, the clinician must coordinate the treatment plan with those providers.
4. The identified clinician will coordinate care with the professional providing medication management, if applicable.
5. Appropriate other mental health and substance related services must be considered.
6. Active treatment must focus on stabilizing or reversing symptoms necessitating admission and developing skills to improve and maintain functioning improvement.
7. Natural supports and community resources must be considered and engaged as available for crisis response.
8. The identified clinician will coordinate with the child's medical providers as needed.
9. Coordination with the clinical treatment plan with identified school staff is required.

Admission Criteria (must meet all)

1. The member must have a valid principal DSM-5 Axis I diagnosis. Recent persistent functional impairments caused by a mental illness (must meet at least one of the following):
 - a. Aggressive physical and/or verbal behavior that disrupts the setting in which they occur
 - b. Recent behavior that poses a direct risk to self or others
 - c. Persistent and validated psychosis that results in a persistent impairment in functioning.
2. The member presents a need for urgent intervention based on serious behaviors requiring immediate intervention.
3. The setting is appropriate for crisis intervention and the member is linked to more intensive treatment if indicated.

Exclusions

Speech/occupational therapy
Music therapy
Equine therapy
Treatment of mental retardation
Educational programming
Day care
Recreation
Respite
Physical restraints/isolation
Settings not appropriate for crisis intervention

Outpatient Applied Behavior Analysis

Criteria for Treatment

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient applied behavior analysis (ABA).

Admission - Severity of Need

There must be documentation of the following:

1. An established DSM 5 diagnosis of Autism Spectrum Disorder as determined by a Child Psychiatrist, Developmental Pediatrician, or Licensed Clinical Psychologist.
2. A severe challenging behavior that:
Presents a health or safety risk to self or others (such as self-injury, aggression toward others,
 - a. Destruction of property, stereotyped/repetitive behaviors, elopement, severe disruptive behavior); *or*
 - b. Significantly interferes with home or community activities.
3. ATEC (Autism Treatment Evaluation Checklist) scores are elevated with expectation of substantial reduction in ATEC scores through ABA intervention.
4. Less-intensive behavior treatment or other therapy has been seriously considered or has not been sufficient to reduce interfering behaviors, to increase pro-social behaviors, or to maintain desired behaviors.
5. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

Admission – Intensity and Quality of Service

All of the following must be met to satisfy the criteria for intensity and quality of service.

1. A reasonable expectation on the part of a qualified treating health care professional¹ who has completed an initial evaluation of the patient, that the individual's behavior will improve significantly with ABA therapy provided by, or supervised by, a Magellan credentialed and contracted ABA provider.
2. The treatment plan [see Autism Spectrum Disorder (ASD) Treatment Plan]² is built upon individualized goals. Objectives are measurable and tailored to the patient based upon an initial baseline ATEC (Autism Treatment Evaluation Checklist) completed by the parent/caregiver.

3. Parent or caregiver training and support is incorporated into the treatment plan and parent or caregiver providing interventions equal to a minimum of one-half the authorized service units.
4. Interventions emphasize generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors.
5. Interventions are consistent with ABA techniques provided by credentialed ABA direct service providers under the supervision of Board Certified Assistant Behavior Analyst (BCABA) with overall clinical direction by a Board Certified Behavior Analyst.
6. The number of service units necessary to effectively address the challenging behaviors is listed in the treatment plan.²

Criteria for Continued Stay

Criteria 1 or 2 **AND** 3, 4, 5 and 6 must be met to satisfy the criteria for continued stay:

1. Patient continues to meet the criteria defined in above admission criteria.
2. Appearance of new problems or symptoms that meet admission criteria.
3. Reasonable expectation that the patient will benefit from the continuation of ABA services and there will be additional reductions in ATEC scores.
4. The treatment plan² is updated on a frequent basis.
5. Measurable progress is documented or there is a reasonable expectation, based on the patient's clinical history and recent clinical experience paired with a substantial change in ATEC scores that the current treatment is of benefit to the patient, such that withdrawal of treatment will result in the patient's decompensation or the recurrence of signs or symptoms that necessitated treatment.
6. Treatment is not making the symptoms persistently worse.

Exclusion Criteria

ABA treatment will not be authorized for any of the following purposes:

1. Speech therapy.
2. Occupational therapy.
3. Vocational rehabilitation.
4. Supportive respite care.
5. Recreational therapy.
6. Orientation and mobility.

7. Persons younger than three years of age or older than eight years of age.
8. When there are concurrent non-emergent individual and/or family therapy through BHIS provider and/or another Iowa Plan provider.

Discharge Criteria

Criteria 1, 2, 3 or 4 must be met to satisfy the criteria for discharge.

1. No meaningful, measurable improvement has been documented in the patient's behavior(s) and/or ATEC scores do not show substantial improvement despite a period of three months of optimal treatment, and there is no reasonable expectation that termination of the current treatment would put the patient at risk for decompensation or the recurrence of signs and symptoms that necessitated treatment.

For changes to be “meaningful” they must be durable over time beyond the end of the actual treatment session, and generalizable outside of the treatment setting to the patient's residence and to the larger community within which the patient resides.

2. Treatment is making the symptoms persistently worse.
3. The patient has achieved adequate stabilization of the challenging behavior and less intensive modes of therapy are appropriate.
4. The patient demonstrates an inability to maintain long-term gains from the proposed plan of treatment.

¹ Qualified treating health care professionals are defined as a Child Psychiatrist, Developmental Pediatrician, or Licensed Clinical Psychologist.

² See www.MagellanofIowa.com for the Autism Spectrum Disorder (ASD) Treatment Plan.

Counseling/Psychotherapy (Mental Health)

Description

Outpatient services are treatment services, provided by qualified mental health professionals and directed toward reversing symptoms of acute mental health disorders, or maintaining stability and functional autonomy for persons with severe and persistent forms of mental health disorders. Outpatient services are specific in targeting the symptoms or problem being treated.

Examples of types of Counseling and Psychotherapy include the following:

- Individual psychotherapy.
- Behavioral therapy.
- Medication management.
- Shared medical appointments.
- Psychiatric, psychological, and psychosocial assessment.
- Group psychotherapy.
- Conjoint/marital therapy.
- Family therapy.

Common settings or sites include providers' offices.

Service Components (must meet all of the following)

1. Professional staff must meet the following conditions:
 - a. Psychiatric consultation must be immediately available to the mental health professional.
 - b. Licensed or certified qualified mental health professionals must provide services; or as approved, an appropriately qualified mental health professional under the direct supervision of a licensed or certified mental health professional must provide services.
 - c. The therapist must provide services within his or her scope of training and licensure.
2. The therapist must thoroughly document the treatment record (see Appendix A for details).
3. The plan must reflect the least restrictive, most efficacious treatment available. For members suffering from chronic mental health disorders, the service plan must include development of specific achievable, behaviorally-based treatment goals that directly address the problems that resulted in the member seeking treatment. For members suffering from chronic or recurrent mental health disorders, outpatient treatment may involve the use of maintenance strategies to promote rehabilitation, maximize function in the community, prevent relapse, and minimize disability.
4. The therapist must include active planning for discharge or transition to a maintenance status.
5. Utilization management staff, if used, must convey accurate, up-to-date information about the member's status and treatment as documented in the medical record.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis. When an Axis II diagnosis is involved, treatment is directed toward the acute symptoms that place the member at risk and/or impair current functioning. All of the following must apply:

1. The member's level of stability must meet both of the following:
 - a. Risk to self or others, if present, is not imminent (although without treatment the member's potential risk in these areas may be increased).
 - b. The member is medically stable and does not require a level of care that includes more intensive medical monitoring.
2. The member's degree of impairment must meet a and b or c:
 - a. The member exhibits impairments in affect, behavior or cognitive functioning, arising from a mental health disorder that indicates a need for outpatient treatment to reverse or stabilize the condition.
 - b. The member exhibits impairment in social, interpersonal, or familial functioning, arising from a mental health disorder that indicates a need for outpatient treatment.
 - c. The member exhibits impairment in occupational or educational functioning arising from a mental health disorder that indicates a need for outpatient treatment to reverse or stabilize the condition.

Continued Treatment Criteria (must meet 1 through 5 and either 6 or 7)

1. The member continues to meet admission criteria.
2. The member is receiving the required services.
3. There is a reasonable expectation that the member will benefit from ongoing outpatient treatment, and the motivation for treatment is established through satisfactory performance of treatment recommendations—
 - a. Magellan defines *benefit* as demonstrated improvement through treatment as validated by objective tracking of progress toward treatment goals. Comparison with the member's pre-morbid or baseline level of functioning suggests that the member has not yet reached his or her achievable level of functioning.
 - b. Magellan defines *motivation* as individual follow-through, with treatment recommendations including, but not limited to, achievement of sobriety, use of medications as prescribed, working on homework assignments, and regular attendance at scheduled therapy sessions.
4. The member is making progress toward goals and is benefiting from the plan of care, as evidenced by the attainment of therapeutic rapport, the lessening of symptoms over time, and the improvement in or stabilization of psychosocial functioning.
5. Treatment promotes self-efficacy and independent functioning. Whenever the therapist employs regressive or dependency-fostering techniques in treatment, they are time-limited in nature and subordinated to a goal of enhanced member autonomy.
6. Current systems significantly impair the member's ability to perform activities of daily living or significantly impair the member's social, occupational, or interpersonal functioning.

7. The member is stable but requires maintenance intervention in order to sustain remission and/or support recovery/rehabilitation. This intervention may include, but is not limited to, pharmacological management.

Mobile Counseling

Description

The purpose of mobile counseling is to bring the services of a therapist to the member's home or community. Members are seen in the natural environment when there is an access issue or for other clinical reasons prevent him or her from gaining access to traditional services in traditional office locations.

Service Components (must meet all of the following)

1. Professional staff—
 - a. Licensed or qualified mental health professionals must provide services, or as approved, an appropriately qualified mental health professional under the direct supervision of a licensed or certified mental health professional must provide services.
 - b. The therapist must provide services within his or her scope of training and licensure.
2. Psychotherapy takes place outside of a traditional outpatient setting (for example, in the member's home or other community setting). Space can not be used for the purposes of seeing multiple members and must be considered safe and accessible.
3. The therapist must thoroughly document the treatment record (see Appendix A for details).

The plan must reflect the least restrictive, most efficacious treatment available. For members suffering from chronic mental health disorders, the service plan must include development of specific achievable, behaviorally-based treatment goals that directly address the problems that resulted in the member seeking treatment. For members suffering from chronic or recurrent mental health disorders, outpatient treatment may involve the use of maintenance strategies to promote rehabilitation, maximize function in the community, prevent relapse, and minimize disability.

4. There must be active planning for discharge or transition to a maintenance status.

Admission Criteria

The member must have a valid principal DSM-5 diagnosis, and all of the following must apply:

1. The member is unable to maintain an adequate level of functioning without this service due to a mental health disorder as evidenced by #2 and #3.
2. Meets counseling/psychotherapy guidelines above. There is a demonstrated need for services to be provided in the member's natural environment rather than a traditional outpatient setting such as concerns related to access due to medical limitations or transportation.
3. The member's medical and mental health needs can be adequately monitored and managed by the clinician(s) involved in the setting outside the clinician's office.

Continued Treatment Criteria (must meet all of the following)

1. The member continues to meet admission criteria.
2. The member continues to need services outside of a traditional outpatient setting.

3. There is a reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
4. The member and family, if appropriate, are making progress toward goals and actively participating in the intervention.

Ambulatory Electroconvulsive Therapy

Description

Psychiatric Electroconvulsive Therapy (ECT) is an established form of treatment that involves passing a carefully controlled electrical current through a person's scalp to trigger a seizure—a rapid discharge of nerve impulses throughout the brain. In recent years, the National Institute of Mental Health, the American Psychiatric Association, and the U.S. Surgeon General all endorse ECT as a valuable tool in the treatment of certain psychiatric disorders, such as Major Depression, Bipolar Depression, and Catatonic Schizophrenia. Although mainly used for adults, ECT may be considered for adolescents with severe suicidal and depressive symptoms and whose illness has not responded to medication or other forms of treatment.

Service Components (must meet all of the following)

1. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:
 - a. Psychiatric history, including past response to ECT, mental status, and current functioning.
 - b. Medical history and examination focusing on neurological, cardiovascular, and pulmonary systems; current medical status; current medications; dental status; review of laboratory test including electrocardiogram, if any; within 30 days prior to initiation of ECT.
2. There is documentation of an anesthesia evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include—
 - a. The member's response to prior anesthetic inductions and any current anesthesia complications or risks.
 - b. Required modifications in medications or standard anesthetic technique, if any.
3. There is a medically necessary and appropriate individualized treatment plan, or its update, specific to the member's psychiatric and/or medical conditions, to address:
 - a. Specific medications to be administered during ECT.
 - b. Choice of electrode placement during ECT.
 - c. Stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
4. There is continuous physiologic monitoring during ECT treatment, to address:
 - a. Seizure duration, including missed, brief, and/or prolonged seizures.
 - b. Electroencephalographic activity.
 - c. Electrocardiographic activity.
 - d. Vital signs.
 - e. Oximetry.
 - f. Other monitoring specific to the needs of the member.
5. There is monitoring for, and management of, adverse effects during the procedure, to include:

- a. Cardiovascular effects.
 - b. Prolonged seizures.
 - c. Respiratory effects, including prolonged apnea.
 - d. Headache, muscle soreness, and nausea.
6. There are post-ECT stabilization and recovery services, to include:
 - a. Medically supervised stabilization services in the treatment area until vital signs and respiration are stable and adverse effects are observed.
 - b. Recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; and electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.
 7. The member is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post procedure recommendation for diet, medications, etc.

Admission Criteria (must meet all of the following)

1. The clinical evaluation indicates that the member has a DSM-5 Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnosis and conditions include, but are not limited to, Major Depression, Bipolar Disorder, Mood Disorder with Psychotic Features, Catatonia, Schizoaffective Disorder, Schizophrenia, Acute Mania, severe lethargy due to a psychiatric condition, and /or psychiatric, syndromes associated with medical conditions and medical disorders.
2. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life threatening inanition, catatonia, psychosis, and/or stupor.
3. One of the following must apply:
 - a. The member has a history of inadequate response to multiple, adequate trials of medications and/or combination treatment, including polypharmacy when indicated, for the diagnosis(es) and condition(s).
 - b. The member is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely.
 - c. The member has a history of good response to ECT during an earlier episode of the illness.
 - d. The patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.
4. The member's status and/or co-morbid medical conditions do not rule out ECT; for example, unstable or severe cardiovascular disease, aneurysm or vascular malformation,

severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (for example, a spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.

5. All of the following will apply:
 - a. The member is medically stable and does not require the 24-hour medical/nursing monitoring or procedure provided in a hospital level of care.
 - b. The member has access to a suitable environment and professional and/or social supports after recovery from the procedure—for example, the member has one or more responsible caregivers to drive the member him or her home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.
 - c. The member can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of him or her and others—for example, the member is prohibited from driving or operating machinery; is complying with the dietary, bladder, bowel, and medication instructions; and is reporting adverse effects and/or negative changes in medical condition between treatments.
 - e. The member and/or a legal guardian is able to understand the purpose, risks, and benefits of ECT, and provides consent.

Continued Stay Criteria (must meet criteria 1 and 2)

1. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
 - a. The persistence of problems that meet the outpatient electroconvulsive treatment admission guidelines.
 - b. The emergence of additional problems that meet the outpatient electroconvulsive treatment guidelines.
 - c. Attempts to discharge to a less intensive treatment will or can be reasonable expected, based on the member's history and/or clinical findings, to result in exacerbation or worsening of the member's condition and/or status.
2. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

Psychological Testing

Criteria for Authorization

Prior to psychological testing, a qualified behavioral health care provider must assess the member to determine the need for and extent of the psychological testing. Testing may be completed at the onset of treatment to assist in the differential diagnosis and/or help resolve specific treatment planning questions. It also may occur later in treatment if the member's condition has not progressed and there is no clear explanation for the lack of improvement.

Severity of Need (must meet criteria 1, 2, and 3)

1. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the member.
2. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.
3. The testing results based on the referral question(s) are reasonably expected to provide information that will effectively guide the course of treatment.

Intensity and Quality of Care (must meet criteria 1 and 2)

1. A licensed doctoral-level psychologist (in explanation, a Ph.D., Psy.D. or Ed.D.) or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, must administer the tests.
2. Requested tests must be valid and reliable, and the most recent version of the test must be used. The instrument must be age-appropriate and meet the member's developmental, linguistic, and cultural requirements.

Exclusion Criteria

Magellan will not authorize psychological testing under any of the following conditions:

1. The testing is primarily for educational or vocational purposes.
2. The testing is primarily for the purpose of determining if a member is a candidate for a specific type or dosage of psychotropic medication.
3. Unless allowed by the member's benefit plan, the testing is primarily for the purpose of determining if a member is a candidate for a medical or surgical procedure.
4. The testing results could be invalid due to the influence of a substance, substance related, substance withdrawal, or any situation that would preclude valid psychological testing results from being obtained (for example, a member who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered).

5. The testing is primarily for diagnosing Attention-Deficit Hyperactive Disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.
6. Two or more tests are requested that measure the same functional domain.
7. Testing is primarily for legal purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing.
8. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.
9. The testing is primarily to determine the extent or type of neurological impairment.
10. The number of hours requested for the administration, scoring, interpretation, and reporting exceeds the generally accepted standard for the specific testing instrument(s), unless justified by particular testing circumstances.

Mobile Crisis

Description

Mobile Crisis Intervention Mental Health Services are mobile assessment, referral, intervention, and triage services that can occur in any one of a number of settings. Such settings can include the member's home, residential placement settings, outpatient clinics, foster homes, emergency rooms, inpatient medical units, etc. Crisis Intervention services include intervention activities of less than 24-hour duration (within a 24-hour period) designed to stabilize a member in a psychiatric emergency. Should the mobile intervention be insufficient to stabilize the person, a determination will be made regarding the immediate initiation of a more intensive level of care.

Crisis intervention services may be appropriate at various points in the member's course of treatment and recovery. Each intervention, however, is intended to be a discreet, time-limited service (in explanation, less than 24 hours for crisis intervention) that stabilizes the person and moves him or her to post-stabilization services prior to returning to more routine level of care services.

Examples of providers of Mobile Crisis Intervention Mental Health Services include the following:

- Mobile crisis team.
- Mobile counselors.

Service Components (all of the following must be met)

1. The setting must provide a safe environment during the intervention.
2. Professional staff and services must include:
 - a. Psychiatric consultation immediately available to the crisis intervention mental health professional.
 - b. Crisis intervention services provided by an independently licensed mental health professional.
 - c. A licensed physician, psychologist (Ph.D.), or social worker should clinically supervise such services when appropriate; in such instances the supervisor should review and co-sign the documentation.
 - d. Services must be provided within the applicable scope of practice guidelines.
3. A crisis response must include a diagnostic interview, risk assessment, Mental Status Exam, family evaluation, review of records, consultation with other professionals, therapeutic interventions with the members and their families, immediate disposition or short-range treatment planning to resolve the crisis, and case management/linkage to the appropriate level of care.
4. Crisis services, including 24-hour telephonic access must be available.
5. Mobile crisis services should not be considered when a serious medical need exists, for example, in the event of a lethal overdose.

Admission Criteria

The member must have a valid DSM-5, and the following must apply:

1. Level of Stability must meet a and b:

- a. The member presents a risk to self, others and/or property that may range from likely to imminent.
 - b. The immediate response is to conduct a thorough assessment of risk, mental status, psychosocial functioning, and medical stability, and, if necessary, to intervene immediately to de-escalate the crisis.
2. Degree of Impairment must meet a and b:
- a. The member has insufficient or severely limited resources or skills necessary to cope with the immediate crisis.
 - b. The member demonstrates impaired judgment and/or lack of impulse control and/or cognitive/perceptual abilities apparently arising from a psychiatric condition or chemical dependence.

Continuing Stay Criteria

Crisis intervention services may be appropriate at various points in the member's course of treatment and recovery. Each intervention, however, is intended to be a discreet, time-limited service (for example, less than 24 hours for crisis intervention) that stabilizes the member and moves him or her to the post-stabilization services, prior to returning to a more routine level of care.

Emergency Nursing Assessment

Description

The Emergency Nursing Assessment (ENA) provides an urgent mental health evaluation to assist the member in stabilizing and reversing symptoms he or she is experiencing.

This service is appropriate when the member is experiencing severe mental health symptoms that require urgent attention. Members who may be medically unstable should be referred immediately to emergency resources, such as a hospital emergency room.

Admission Criteria (all of the following must be met)

1. Provide the service *only* in a safe environment.
2. ENA services should not displace other routine mental health services, such as office-based therapy. The ENA is for members who do not have access to a scheduled appointment and are experiencing severe symptoms.
3. An Iowa-licensed registered nurse (RN) with psychiatric experience can perform the ENA, providing all activities under a physician's order. The components of this assessment should include, at a minimum, the following:
 - a. Current mental status and risk information.
 - b. Assessment of suicidal ideation, plan, intent, high risk factors, means, plan to diminish risk/access to means.
 - c. Relevant mental health and substance related history.
 - d. "Why now" factors that led to the member presenting for treatment at this time
 - e. DSM – 54 Axis I through V.
 - f. Treatment recommendations, including site and type of care.
 - g. Crisis plan.

Continuing Stay Criteria

ENA services may be appropriate at various points in the member's course of treatment and recovery. Each intervention, however, should be a discreet, time-limited service (for example, less than 24 hours for crisis intervention) that stabilizes the member and moves him or her to the post-stabilization services prior to returning to more routine level of care.

Co-Occurring Case Management

Description

Co-Occurring Case Management services are direct outpatient services delivered in the member's home or residence and/or in a community setting. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of systems for highly recidivistic adults with serious and persistent mental illness and a diagnosis of a substance related disorder. Services assist the member in gaining access to needed resources and services in order to achieve stability in the community and avoid hospitalization/residential care.

Service Components (must meet all of the following)

1. The supervisor either has a master's degree or a bachelor's degree and five years of case management experience and case management training.
2. Unlicensed program workers are supervised closely, and services provided are within the worker's scope of training and experience.
3. Services are coordinated with the member's mental health therapist or psychiatrist and other service providers.
4. There is a complete biopsychosocial assessment including, but not limited to, relevant history, education or employment, social skills, independent living skills, previous treatment, current medical conditions (including medications), substance related history, and lethality assessment.
5. The development of an individualized strengths-based, targeted, focused plan directed toward the reduction or alleviation of the impairment that resulted in the member seeking services. The plan must reflect the least restrictive most efficacious services available.
6. The development of specific, achievable, behavioral-based, objective goals that directly address the programs that resulted in the member seeking services.
7. The case manager, with the member, develops a service plan that includes the following:
 - a. Documented assessment of the member's strengths and needs
 - b. Specific goals, objectives, responsible persons, time frames for completion, and the case manager's role in relating to the member and others involved.
8. Services provide the member with assistance to link with services, gain access to services, monitor the delivery of services, resolve problems, use community resources, and network building.

Admission Criteria (must meet all of the following)

1. Dimension I—Acute intoxication/withdrawal potential
 - a. The member has a history of service use for the treatment of intoxication/withdrawal. Past experiences in this dimension have caused impairments in daily functioning.
2. Dimension II—Biomedical conditions
 - a. The member may have medical issues that complicate the access or continuation of mental health/substance related treatment services.
3. Dimension III—Emotional/Behavioral

- a. The member has a risk rating of 1 or higher, with narrative rationale.
- 4. Dimension IV—Readiness for change
 - a. The member seeks and actively participates in a joint provider/member assessment, and the provider and member jointly agree that the member desires, is committed to, and will likely benefit from case coordination services.
- 5. Dimension V—Relapse potential
 - a. The member has a risk rating of 2 or higher with narrative rationale. The individual has a personalized, behaviorally based relapse plan with action steps consistent with past use patterns.
- 6. Dimension VI—Social support/recovery environment
 - a. The member has factors in his or her support environment that prevent the self-management of the treatment plan.
- 7. The member is unable to maintain an adequate level of functioning without this service because of a mental health *and* substance related disorder as evidenced by the following:
 - a. Moderate to severe symptoms of mental illness of sufficient duration to receive a DSM-5 diagnosis from a licensed independent mental health professional and; decomposition of mental health; substance related relapse or continued substance use despite exacerbation of mental health symptoms
 - b. There has been a failure to stabilize the member’s functioning with less intensive services.
- 8. The member is not receiving duplicate case management services from another provider.

Continuing Stay Criteria

- 1. The member continues to meet criteria defined above in Admission Criteria.
- 2. There is a reasonable expectation that the member will benefit from continuing case management services. This is observable as a positive or beneficial response to services that may include, but are not limited to, the following:
 - a. Consistently attending scheduled therapy sessions/case management meetings.
 - b. Independent living.
 - c. Vocational/educational participation.
 - d. Reduced hospital lengths of stay.
 - e. Reduced use of crisis-only services.
- 3. The member is making progress to the extent possible toward goals and is benefiting from the service plan as evidenced by lessening of symptoms and stabilization of psychosocial functioning; the removal of case management services would result in destabilization of the member.
- 4. The techniques employed in case management are time limited in nature and subordinate to a goal of enhanced member autonomy.

Telehealth Psychiatric Care Coordination

Service Description

1. Staff acts as the single point of contact for members/family members for telehealth visits. Educates participants on the process and answers any questions.
2. Ensure completion of necessary documents.
3. Monitor for indications that telehealth may not be clinically appropriate.
4. Liaison with appropriate resources in the case of technical issues with telehealth.
5. Coordinate telehealth visit activity and participation by the member/family and provide communication assistance or clarification if needed.
6. Follow up with documentation and/or prescriptions necessary to the telehealth visit.
7. Be available for follow-up with members/family members after the telehealth visit for information, questions, support, and liaison with psychiatrist, if necessary.
8. Coordinate diagnostic, treatment, and medication information to the member's primary care provider or other providers as appropriate.
9. Coordinate completion of necessary laboratory testing/results and necessary communication with the psychiatrist.
10. Coordinate necessary referrals as a result of the telehealth visit.
11. Perform appointment reminder calls to members and family members for the telehealth visit.

Admission and Continued Stay Criteria

The member who uses telehealth services must meet the criteria established for Outpatient Counseling/Psychotherapy.

Section III: Recovery and Resiliency Services

Peer Support (Mental Health and Substance Related Disorders)

Description

The Peer Support Specialist (PSS) provides peer support services in the home and/or community, serves as a member advocate, and provides member information and peer support for members in emergency, outpatient, or inpatient settings as well as transitional services from a 24-hour level of care. The PSS performs a wide range of tasks to assist members in regaining control over their own lives and over their own recovery process. The PSS will role model competency in recovery and ongoing coping skills.

There is recognition that members in recovery from persistent mental health issues may be trying to regain control of their lives. At the same time, members struggling with addiction issues may have given up a certain amount of control to advance their personal recovery.

Service Components (must meet all of the following)

1. A peer support program will provide services utilizing trained adult peer support specialists, who have been members of mental health/substance related services, have worked on their own recovery and can share those experiences.
 - For mental health, peer support specialists have experienced a serious mental illness and can articulate a recovery experience that can be shared in a helping role.
 - For substance related problems, peer support specialists are in a recovery program from an abuse or dependence diagnosis. There are in a position to share those experiences with others in a helping role.
2. Maximum caseload ratio of 15 members to one Peer Support Specialist.
3. A Peer Support Specialist has a minimum of four contacts per month with the member, with at least three contacts being face to face. Services can be provided through:
 - Individual face to face support.
 - Telephonic support.
 - Peer support activities in a group setting.
4. Magellan contracts with a mental health organization for peer support, The peer support program directly provides the following services in the home and community, including but not limited to:
 - Assisting members in developing personal goals for recovery from mental health and/or substance related disorders.
 - Developing an individualized crisis plan for each member.
 - Developing warm lines and crisis calling trees for members/PSS.

- Assisting members in developing a recovery action plan, using Wellness Recovery Action Planning techniques.
 - Teaching and role modeling the value of every individual's recovery experience.
 - Developing a supportive relationship.
 - Utilizing and teaching problem solving techniques with individuals and groups.
 - Modeling effective coping techniques and self-help strategies.
 - Attending treatment team meetings to promote members use of self-directed recovery tools and coordinating care with other providers.
5. Services are supervised by behavioral health professionals who are Magellan credentialed organizational providers and:
- Who conduct a minimum of twice monthly clinical supervision meetings with one licensed independent mental health professional and the PSS.
 - Who provide access to initial and ongoing training in basic mental health and substance related symptomatology, crisis management, and recovery concepts to the PSS.
 - Provide initial training based on the Georgia Model of Peer Support or equivalent training with a competency exam for each PSS.
6. The PSS has access to a mental health/substance use professional within the organization 24/7 for crisis support.
7. Members should be matched with PSS who have similar backgrounds. For example, a member with substance related disorder should be matched with a PSS who has completed a primary substance related treatment intervention.
8. Maintain an advisory committee with 51% member membership, to meet a minimum of quarterly.

Admission Criteria: (must meet all of the following)

1. Validated principal DSM-5 diagnosis. Member receiving services has a serious and persistent mental illness and/or a substance related diagnosis.
2. Level of recovery:
 - a. The member's behavior does not put the health and safety of the Peer Support Specialist at risk, as deemed by the supervisor or other information available.

- b. The member chooses to be involved with peer support services.
3. Expectation of benefit (must meet a and b or c)
- a. Member demonstrates a need for support in the living, learning, working, and/or social environments.
 - b. An assessment has determined this service will assist in the above functioning areas for the member. It should be shown that expected benefits from the service cannot be provided by other resources available to the member.
 - c. It is assessed the member needs assistance in a recovery plan to initially engage in substance related treatment or to continue recovery after a primary substance related treatment intervention.

Continued Treatment Criteria (must meet all)

- 1. Continue to meet admission criteria.
- 2. Based upon an individualized service plan with measurable goals and action steps, there is a reasonable expectation the member will benefit from peer support services.
- 3. Transition plans are developed collaboratively to identify supports independent of peer support services.
- 4. An annual assessment will be conducted of benefit of peer support services unless risk or other clinical issues require closer follow up.

Family Peer Support (Mental Health)

Description

Family Support interventions are collegial services delivered in the community, such as the family home or residence and/or community settings. The services are targeted toward the support of a child under age 21 with a serious emotional disorder and their family. Such services are supportive and may be rehabilitative in focus and are initiated when there is a reasonable likelihood that such services will benefit the individual's functioning and assist them in maintaining community tenure in the familial home.

Family Support providers must be accredited under Chapter 24 of the state of Iowa and must have access to a psychiatrist for clinical leadership of the Family Support services provided, including planning specific interventions to meet the goals of the family.

Family Support Service components include:

- Assistance in navigating the mental health and substance related education, and when needed, the child welfare systems.
- Assist parents' access to services and community resources.
- Transportation.
- Ongoing support for the child and family in one to one and/or group format.
- Communication between the family and providers.
- Assist parents in developing advocacy skills.
- Assistance in attending appointments and obtaining medications.
- Accompany parents to wraparound meetings and IEP meetings.
- Crisis intervention and development of a crisis plan.
- Development and coordination of natural mental health support systems.

Provision of specific Family Support components must be preceded by documentation of individual member needs as determined through initial assessment and on-going reassessment.

Service Components (must meet all of the following)

1. A Family Support program will provide services directly to parents with a young (less than 21 years-old) family member with SED.
2. A family support specialist will have a parenting experience of a child with SED. They will be in a position to articulate that experience in a manner to help other family members.
3. Services are directly supervised by mental health professionals who are licensed at the independent practice level. Services are provided by Magellan-credentialed organizational providers.
4. An independently Iowa licensed mental health professional must be available by phone to Family Support providers on a 24-hour basis.

5. A minimum of twice monthly supervision meeting must be provided to Family Support providers by licensed independent mental health professionals. (Supervision must encompass mental health issues that affect those with serious emotional disorders.)
6. Supervision provided must be within the scope of practice and licensure for the mental health professional.
7. Family Support providers must have access to initial training of basic mental health symptoms, crisis identification, mental health and psychosocial service systems, substance related problem identification and relapse prevention. A curriculum from Georgia and Kansas has been approved for content with the Family Support Specialist passing an exam upon completion.
8. Parents providing Family Support must have access to at least one hour per month of ongoing training from parents who have experience in providing Family Support and/or Magellan approved training.
9. Every effort should be made to match parents with Family Support providers with similar backgrounds.
10. Case loads will be kept at manageable levels to enhance ability of Family Support providers to interact with parents and provide support in an individualized manner.
11. A Family Support program will appoint parents to approve of all management decisions regarding the design, deliver, and monitoring of Family Support services.
12. A Family Support program directly provides the following services in the home and community:
 - Development of a Family Support Plan.
 - Provide Education and Family Support for parents and primary caregivers.
 - Model healthy coping strategies, stress management and parenting.
 - Monitoring mental health symptoms and functioning/reality orientation.
 - Supportive relationship.
 - Provide support, a positive example, promote healthy parent-child relationships through shared, lived experience.
 - Assistance in navigating the mental health, substance related disorders education, and when needed, the child welfare systems.
 - Provide information to help parents interpret system requirements and provider options.
 - Crisis intervention and development of a crisis plan.
 - Development and coordination of natural mental health support systems.

Admission Criteria (must meet all of the following)

Validated principal DSM-5 Axis I diagnosis. Primary diagnosis of developmental disability disorders is excluded.

1. Level of Stability (must meet a, b and c)
 - a. Individual is presently under the psychiatric care of a board-eligible psychiatrist or other qualified physician.
 - b. If risk to self, other, or property is present, it is determined that this can be managed by the current clinical team within the existing environment.
 - c. The individual is medically stable and does not require a level of care that includes more intensive medical monitoring. If not medical stable, then the individual has the necessary medical resources to medically stabilize.
2. Degree of impairment (must meet a and b)
 - a. The child's functioning level is impaired due to a serious emotional disturbance despite continued outpatient interventions. Mental health symptoms interfere with day to day functioning at home and school. Hospitalization for mental health and/or out of home placement has been accessed or considered.
 - b. Social/Interpersonal/Familial/-Mental health symptoms interfere on a day to day basis with the parental relationships and with peers. Impairment at school is present due to mental health symptoms.
3. Support
This service is needed and the supports provided cannot be offered through existing services and/or natural support systems.

Continued Treatment Criteria (must meet 1 through 4)

1. Continue to meet admission criteria.
2. Based upon an individualized treatment plan with measurable goals and objectives, there is a reasonable expectation that the individual will benefit from the Family Support Program.
3. Transition plans are made for the individual to develop independent support from peers via modeling the Family Support relationship.
4. Individual and family continues to express a desire to continue with this intervention.

Exclusion Criteria

1. In the absence of client transitioning to independent support development, concurrent Peer Support services are not concurrently engaged.
2. Primary diagnosis of developmental disability disorders.

Integrated Mental Health Services and Supports

Description

Integrated Mental Health Services and Supports—informal services and supports that providers, family and friends, and other members of the natural support community offer—must be integrated into the treatment plan. These interventions help individuals remain in or return to their homes, and they limit the need for more intensive out-of-home mental health treatment. Integrated services and supports are specifically tailored to an individual member's needs at a particular point in time. They are not a set menu of services.

A joint treatment planning process may identify the need for integrated services/supports. The member/family member must lead the planning process, with other members of the team giving their input. Individual contacts with the member/family also may identify the need for these services and supports.

Ideally, these services and supports provide more flexibility in providing members with unique services that address their mental health needs and in augmenting and complementing those provided through other funders and systems. Some natural support involvement may require reimbursement, and at other times they may be part of the family process.

Examples of Integrated Mental Health Services and Supports include the following:

- Peer mentor.
- Family support person.
- Transportation.
- Hotel for parent to attend treatment of child.
- Swimming lessons.

Service Components (must meet all of the following)

1. Services and supports must be approved as part of a joint treatment planning process or individual contact with the member or family.
2. Service and supports must be coordinated with current providers
3. The development of an individualized, focused service plan is directed toward the prevention of out-of-home care or more intensive services by the member seeking intervention; the plan must reflect the least restrictive intervention available
4. The development of specific, achievable, behavioral-based, and objective service goals that directly address the problems and/or disability that resulted in the member seeking treatment and/or rehabilitation.
5. Specific recovery and/or resiliency skills and supports are identified as part of the treatment plan.

Admission Guidelines

The member must have a valid principal DSM-5 diagnosis and meet 1 or 2:

1. The member must be unable to maintain an adequate level of functioning without this service due to a mental health disorder as evidenced by a and either b or c.

- a. Severe symptoms and/or history of severe symptoms for a significant duration.
 - b. Impairments in performing the activities of daily living.
 - c. Significant disability of functioning in at least one major life area including social, occupational, living, and/or learning.
2. It is the consensus of the treatment team that the authorization of services and/or supports is imperative to a recovery plan. For the child and family, the services and/or supports are part of a wraparound plan and/or development/enhancement of resiliency skills.

Continued Treatment Criteria (must meet all of the following)

1. Continues to meet admission criteria.
2. Recovery requires a continuation of these services.
3. The reasonable likelihood of substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.
4. The member—and family as appropriate—is making progress toward goals and actively participating in the interventions.

Rehabilitation and Support

Description

Rehabilitation and Support Services are comprehensive outpatient services that are based in the member's home or residence and/or community setting. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or the amelioration of symptoms of mental disorder. Such services are directed primarily to individuals with severe and persisting mental disorders and/or complex symptoms, and who require multiple mental health and psychosocial support services. Such services are active and rehabilitative in focus and are initiated and continued when there is a reasonable likelihood that such services will lead to specific observable improvements in the member's functioning.

Examples:

- Intensive Psychiatric Rehabilitation (IPR) services.
- Individualized services.

Service Components (must meet all of the following):

1. A qualified mental health professional supervises services—
 - a. The supervisor or manager must be licensed or certified at the independent practice level; for programs accredited by the Department Human Services, the supervisor or manager must meet the program and service accreditation standards in IAC 441-24.
 - b. Unlicensed program workers must be supervised closely, and all documentation must be counter-signed by the licensed supervisor, qualified as defined in 1a above.
2. Services provided must be within the worker's scope of training and experience.
3. Services include a biopsychosocial assessment—completed by a practitioner or obtained from another provider—that contains information relevant to the service provided. The biopsychosocial assessment may include, but is not limited to, relevant history, previous interventions and their impact, current medical conditions including medications, substance related history, lethality assessment, and complete mental status.
4. Development of an individualized, focused service plan directed toward the reduction or alleviation of the impairment and/or rehabilitation of the disability that resulted in the member seeking intervention. The plan must reflect the least restrictive, most efficacious intervention available.
5. Development of specific, achievable, behavioral-based, and objective service goals that directly address the problems and/or disability that resulted in the member seeking treatment and/or rehabilitation.
6. When appropriate for a given member, direct mental health treatment services are provided as part of the program by a qualified mental health professional, or an appropriate referral is made to a direct mental health treatment provider.
7. When appropriate for a given member, provision and/or coordination of social, vocational rehabilitation, and/or other community services are included as part of the program.

Admission Guidelines

Valid principal DSM-5 diagnosis and all of the following:

1. The member is unable to maintain an adequate level of functioning without this service due to a mental health disorder as evidenced by a and either b or c:
 - a. Severe symptoms and/or history of severe symptoms for a significant duration.
 - b. Inability to perform the activities of daily living.
 - c. Significant disability of functioning in at least one major life area including social, occupational, living, and/or learning.
2. The member seeks and actively participates in a joint provider/member assessment, and the provider/member jointly agree that the member desires, is committed to, and will likely benefit from the supportive/rehabilitation process.
3. The interventions necessary to reverse, stabilize, or enhance the member's condition require the frequency, intensity, and duration of contact provided by the rehabilitative and/or support service professional as evidenced by either or both of the following:
 - a. Failure to reverse/stabilize/progress with a less intensive intervention.
 - b. Need for specialized intervention for a specific impairment or disability.

Continued Treatment Criteria (must meet all of the following):

1. Continues to meet admission criteria.
2. Recovery requires a continuation of these services.
3. The reasonable likelihood of substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.
4. The member—and the family as appropriate—is making progress toward goals and actively participates in the interventions.

Community Support Services

Community Support Services (CSS) are provided to adult members with a severe and persistent mental illness (SPMI). CSS is designed to support members as they live and work in their communities by reducing or managing mental illness symptoms and associated functional disabilities that negatively affect community integration and stability.

Iowa Plan CSS providers must be accredited under Chapter 24 of the state of Iowa and must have access to a psychiatrist for clinical leadership of the CSS services provided, including planning specific CSS interventions to improve symptoms and functioning.

CSS staff must have knowledge and experience in working with adults with SPMI and should have the ability to create relationships with members that balance support for mental illness symptoms and functional disabilities with maximum individual independence.

Community Support Services components include:

- Monitoring mental health symptoms and functioning/reality orientation.
- Transportation.
- Supportive relationship.
- Communication with other providers.
- Assistance in attending appointments and obtaining medications.
- Crisis intervention and development of a crisis plan.
- Development and coordination of natural mental health support systems.

Provision of specific CSS components must be preceded by documentation of individual member needs as determined through initial assessment and on-going reassessment.

CSS SERVICE LEVELS

There are two levels of Iowa Plan Community Support Services. Each level is described below. The level of CSS provided must be consistent with the member's assessed need at a certain point in time or across a time period. While minimum contact requirements are included in the descriptions below, CSS providers should see each member at a frequency consistent with that member's assessed needs. At both levels, CSS staff must plan CSS service components in conjunction with the member's psychiatrist or with a provider-affiliated psychiatrist.

High Intensity CSS

Criteria for Admission - High Intensity CSS is for members who:

1. Experience increased psychiatric symptoms that require increased support and close follow-up to continue living in the community. *Or*
2. Have persistent psychiatric symptoms and a pattern of community living that require long-term support and close follow-up to assist in living in the community.

Frequency of Contact/Service Provision - High Intensity CSS is provided through 5-12 contacts per month. Contacts may be face-to-face or by telephone, with a minimum of 4 face-to-face contacts required per month. CSS staff must have at least 2 contacts with the psychiatrist per month to plan High Intensity CSS service components. All contacts with the member and the psychiatrist must be documented in the CSS progress notes.

Service Monitoring/Authorization - High Intensity CSS services must be authorized by the Magellan Care Manager. For authorization of High Intensity CSS to continue, the member must continue to meet the Criteria for Admission and there must be expected treatment benefits associated with High Intensity CSS.

Low Intensity CSS

Criteria for Admission - Low Intensity CSS is for members who:

1. Require periodic supportive services to maintain their level of independent functioning in the community. Without Low Intensity CSS, these members may become socially isolated and may exhibit increased symptoms of mental illness and associated functioning disabilities that put them at risk for a more restrictive level of care than their normal community environment.

Frequency of Contact/Service Provision - Low Intensity CSS is provided through 2-4 contacts per month, with occasional episodes of increased frequency. Contacts may be face-to-face or by telephone, with a minimum of 1 face-to-face contact required per month. CSS staff must have at least 1 contact with the psychiatrist every three months to plan Low Intensity CSS service components. All contacts with the member and the psychiatrist must be documented in the CSS progress notes.

Service Monitoring/Retrospective Review - Low Intensity CSS services do not require authorization by Magellan but services are monitored by Magellan through retrospective review. Members must continue to meet the Criteria for Admission and there must be expected treatment benefits associated with Low Intensity CSS.

Assertive Community Treatment

Description

Assertive Community Treatment (ACT) is a comprehensive and intensive outpatient service delivered within the community, such as in the member's home or residence and/or in other community settings. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of symptoms of mental disorder. Such services are primarily for members with severe and persistent mental disorders and/or complex symptoms that require multiple mental health and support services to maintain the member in the community. Such services are active and rehabilitative in focus, and the clinician initiates them when there is a reasonable likelihood that such services will lead to specific, observable improvements in the member's functioning and will assist the member in achieving and/or maintaining community tenure. The Magellan ACT Team participates in all mental health services provided to members.

Examples of Assertive Community Team (ACT) services include the following:

Service Components (must meet all of the following):

1. The ACT program provides services directly by a multi-disciplinary team, including, at a minimum:
 - a. A board-certified or -eligible psychiatrist with admitting privileges in a Magellan network hospital that is accessible to members.
 - b. A registered nurse.
 - c. A licensed mental health professional.
 - d. Other team members with competencies in the treatment of adults with a serious and persistent mental illness.
 - e. A vocational specialist.
2. At least one staff member who has competency in treating dual diagnosis members (mental illness and substance use disorders).
3. Qualified mental health professionals directly supervise services.
4. The supervisor or manager is licensed or certified at the independent practice level.
5. Unlicensed program staff is supervised directly, and the licensed supervisor countersigns all documentation.
6. Services provided must be within the therapist's scope of training and licensure.
7. Case loads are kept at manageable levels to enhance ability of ACT team staff to interact with members and respond to situational needs of members, for example, 10 members to 1 staff member.
8. Team meetings occur daily for the ACT team staff, including the psychiatrist
9. An ACT program directly provides the following services in the home and community:
 - a. Complete biopsychosocial assessment including, but not limited to, relevant history, previous interventions and their impact, current medical conditions

including medications, substance related history, lethality, assessment and complete mental status exam

- b. A comprehensive service plan that the ACT team develops, implements and services; the service plan will focus on individual rehabilitation and development of individual competencies directed at reduction or alleviation of the impairment that led to the member seeking treatment; the plan must reflect the least restrictive, most efficacious treatment available.
 - c. Psychotherapy/counseling.
 - d. Medication administration and management.
 - e. Crisis response and outreach available 24 hours a day, 7 days week, by ACT team members and including psychiatric consultation.
 - f. Services available 365 days per year, routine services should be available on weekends and holidays.
 - g. Home and community-based social and basic living skills training development.
 - h. Vocational rehabilitation services.
 - i. Assistance in accessing and coordination of community services and programs.
 - j. Case management services, including assertive and proactive outreach to the home and community.
 - k. Substance related services, as appropriate.
10. ACT services should maximize self-reliance and community tenure of all members.

Admission Criteria (must meet all of the following):

1. Validated principal DSM-5 Axis I consistent with a serious and persistent mental illness.
2. Exclusion of diagnosis of primary substance related disorder, developmental disability, or organic disorders.
3. Level of Stability must meet a or b, and all of c, d, and e:
 - a. A pattern of repeated treatment failures with at least 2 hospitalizations within the previous 24 months.
 - b. The member needs multiple and/or combined mental health and basic living supports to prevent the need for more an intrusive level of care.
 - c. Low consideration of risk to self, others, or property (although without treatment or support, the member's potential risk in these areas may increase).
 - d. The member is medically stable and does not require a level of care that includes more intensive medical monitoring.
 - e. The member lives independently in the community or demonstrates a capacity to live independently and transform from a dependent residential setting to independent living.
4. Degree of Impairment must meet a and b and may meet c:
 - a. Individual does not have the resources or skills necessary to maintain an adequate level of functioning in the home environment without assistance or support, and he or she exhibits impairments arising from a psychiatric disorder that

compromises his or her judgment, impulse control, and/or cognitive perceptual abilities.

- b. Individual exhibits significant impairment in social, interpersonal, or familial functioning, arising from a psychiatric disorder that indicates a need for assertive treatment to stabilize or reverse the condition.
- c. Individual exhibits impairment in occupation or educational functioning, arising from a psychiatric disorder that indicates a need for counseling, training, or rehabilitation services or support to stabilize or reverse the condition.

Continued Stay Criteria must meet 1 through 4:

1. Validated DSM-5 Axis I diagnosis with resilient symptoms, which continues to have a broad and persistent effect on the member's ability to effectively manage day-to-day activities of living and self support on an independent basis.
2. There is a reasonable expectation that the member will benefit from the ACT program. As measured by an observable positive or beneficial response to treatment, including, but not limited to, medication adherence, homework assignments, and collaborating with the ACT team in treatment.
3. Individual is making attempt/progress toward goals and is benefiting from the plan of care, as evidenced by attainment of therapeutic rapport, lessening of symptoms over time, and stabilization of psychosocial functioning through service planning, homework, and team involvement.
4. Treatment promotes individual self-efficiency and maximizes independent functioning. Employment of treatment techniques encourages use of natural support systems to promote a member's mastery of his or her environment.

Home-Based Habilitation (HBH)

Description

These services are designed to help the member with skills and supports necessary to improve their daily functioning relative to a serious mental illness. Skills and support needs are identified in the assessment to formulate a treatment plan for services.

These services are managed by an Integrated Health Home (IHH) or case manager to become part of a Person Centered Plan. There should be regular communication amongst the IHH staff, Habilitation supervisor, in-home nursing resources and psychiatrist as well as additional coordination, as indicated, with other treatment providers.

Services can be both supportive and skill-based according to the member's identified needs and goals.

Specific HBH interventions include:

- Services provided in the person's home and community.
- Assist the member to reside in the most integrated setting appropriate to the member's needs.
- Provide for the daily living needs of the member to help build a routine in recovery from a serious mental illness. Typical examples would be assistance with medications, budgeting, grocery shopping, cooking, personal hygiene skills and integrating into the community. Interventions to improve social relationships and integration with the community.
- Assist with access to purposeful activity.
- Staff support (up to 24 hours a day) to assist the member in coping, relative to urgent symptoms and or poor functioning.

Service Components (Must meet all the following):

1. All services are under a supervisor with a bachelor's level degree and five years of experience with behavioral health.
2. Supervisor access is available 24 hours a day, seven days a week.
3. Specific case supervision with habilitation staff occurs weekly commensurate with the service intensity and individual member needs.
4. Person Centered Planning Meeting occurs at least annually with the plan available for authorization review. More frequent plan development will be determined by case specific needs.

Authorization Criteria

Intensive I to III (Each service level must meet 1 and either 2 or 3):

1. Severe mental health symptoms and/or history of severe symptoms for a significant duration, *and*
2. Inability to perform the activities of daily living. *Or*
3. Significant disability of functioning in at least one major life area including social, occupational, living and/or learning.

Level Specific Criteria

Intensive III: 17 to 24 hours per day every day (Must meet 1, 2 or 3, 4 and 5):

1. For members who demonstrate an impairment of functioning as a result of a serious mental illness (SMI).
2. Recent hospital stays, ER use or use of emergency services.
3. The member has significant risk of harm to self or others or disturbance of mood, thought, or behavior which renders him/her incapable of appropriate self care or self regulation.
4. This service has approval by the member's psychiatrist or other appropriate clinician.
5. Treatment plan developed with the goal of stabilization as demonstrated by freedom from criteria 2 and 3.

Intensive II: 13 to 16.75 hours per day every day (Must meet all of the following):

1. 24 hour staff not needed.
2. 30 days free of any significant self harm/harm to others.
3. Structured and meaningful activity outside their residence.
4. Safety and supervision necessary for most during all waking hours of the day.
5. Member needs significant support to complete basic living skills.
6. Treatment plan development with the goal of stabilizing the member's daily routine, including but not limited to, supporting the member to complete ADLs to gain competency and more independence.

Intensive I: 9 to 12.75 hours on the days of service (Must meet all of the following):

1. 90 days free from any significant self harm or harm to others.
2. Member requires significant support/skills interventions with:
 - a. Problem solving.
 - b. Emotional management.
 - c. Coping skills.
 - d. Relaxation/self-regulation.
 - e. Crisis planning and implementation.
3. Assistance for increased participation in the community – working, volunteering and other meaningful opportunities.
4. Treatment plan development with the goal of helping the member prepare for greater independence and community integration.

Medium Need: 4.25 to 8.75 hours on the days of service (Must meet all the following):

1. 90 days free from any significant self harm or harm to others
2. Member requires significant support/skills interventions with:
 - a. Problem solving.

- b. Emotional management.
 - c. Coping skills.
 - d. Relaxation/self-regulation.
 - e. Crisis planning and implementation.
 - f. Other individualized skills identified by member.
3. Increased participation in the community – working, volunteering and other meaningful opportunities.
 4. Member is capable of basic activities of daily living.
 5. Treatment plan development with the goal of helping the member prepare for greater independence and community integration.

Recovery Transitional: 2.25 to 4 hours on the days of service (Must meet all the following):

1. Demonstrating more autonomous community navigation.
2. Follows a schedule and is able to leave their home for purposeful activity OR they may engage in meaningful activity at home without Habilitation provider present.
3. Treatment plan development for progress towards goals of continued management of their ADLs, interacting with their community and personal/member defined goals.

Recovery High: 0.25 to 2 hours on the days of service (Must meet all the following):

1. Needs periodic contact for medication adherence and/or monitoring of status and recovery maintenance.
2. Demonstrating good use of community, family and other natural supports.
3. Engaging in purposeful activity in line with the member's values and beliefs.
4. Making progress in managing daily routine without staff intervention.

Frequency of Service: The intensive levels will be provided daily to members based on those identified needs.

For medium and recovery levels, the services can be provided according to the needs of the member.

Appendix A

Documentation Requirements - All Levels/Sites of Care

Evaluation of the treatment record is based on documentation of the following types of information or documentation:

- Technical.
- Assessment.
- Problem Formulation.
- Treatment.

Technical

1. Unambiguous identification of the member's full name appears on all pages; the member's Medicaid number and member's birth date also appears in the document.
2. The record includes the member's current—
 - a. Address.
 - b. Employer or school.
 - c. Home and alternative telephone numbers.
 - d. One emergency contact including address and telephone number.
 - e. Marital/legal status of member.
 - f. Ethnic origin.
 - g. Signed member rights statement, consent to treatment and authorization to disclose confidential information.
 - h. Member consent/coordination with PCP.
 - i. Guardianship information.
3. The record should indicate that the legal party responsible for the well-being of the member has given their informed consent to evaluation, communication, and treatment.
4. Each clinical entry—signed by appropriately credentialed practitioner with professional degree—should clearly indicate date, time, type of contact, practitioner, and practitioner's profession.

Assessment

1. Description and history of presenting problems(s) including precipitating and proximal "Why Now?" factors.
2. A mental status examination that includes an evaluation of the member's—
 - a. Orientation to person, place and time.
 - b. Appearance.
 - c. Affect.
 - d. Speech.
 - e. Mood.

- f. Thought content/process.
 - g. Intellectual level.
 - h. Judgment.
 - i. Insight.
 - j. Attention/concentration.
 - k. Motivation/cooperation level.
 - l. Memory.
 - m. Impulse control.
3. A risk assessment, which is part of every evaluation. Assessment of risk factors using multiple methods (for example, a questionnaire) and considering cultural issues. The assessment prominently notes special situations—such as imminent risk of harm, suicidal ideation, or elopement potential—with updated crisis plans developed with member’s input. Members who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
 4. Functional Assessment (with age appropriate expectations)
 - a. Specific complaints regarding completing activities of daily living.
 - b. Ability to attend school and/or job.
 - c. Ability to perform age appropriate functions, e.g. dressing self.
 - d. Ability to follow stepwise directions for household chores.
 - e. Ability to self-restrain as redirected.
 - f. Ability to maintain and/or attend to basic hygienic needs independently or as instructed by supportive party.
 - g. Ability to comply with medical expectations, e.g. medication compliance, diet, exercise.
 - h. Ability to manage age appropriate finances, e.g. paying bills, tracking financial resources, budgeting.
 - i. Ability to navigate in their community.
 - j. Ability to express appropriate needs and desires and work to operationalize attainment of such.
 5. Substance Use History
 - a. Substances used in past and present.
 1. Duration.
 2. Frequency.
 3. Quantity per occurrence, per day, per week.
 - b. Consequences and/or impairments due to use.
 - c. Prior treatment.
 1. Level of Care.
 2. Outcome.

- d. Referrals to substance related provider.
6. For members 12 years of age and older, documentation includes past and present use of tobacco products, caffeine, and alcohol as well as illicit, prescribed, and over-the-counter drugs. For all members (adult and child), documentation also includes the history of inappropriate substance use for the member and his or her family. If appropriate, documentation also includes drug and alcohol referral with evidence of collaboration.
7. The treatment record should document a detailed medical and behavioral health history that includes the following:
 - a. Previous practitioners and treatment dates.
 - b. Therapeutic interventions and responses.
 - c. Sources of clinical data.
 - d. Relevant family information/natural support systems.
 - e. Member identified inner strengths and social conditions.
 - f. Member's talents/skills/abilities/preferences/achievements are explored and documented.
 - g. Results of laboratory tests and psychological tests.
 - h. Allergies.
 - i. Consultation reports.
8. The record documents an appropriately detailed psychosocial history, which includes items such as family, educational, religious preferences, cultural needs, occupational, relevant legal, services provided by other delivery systems, living arrangements, mobility (in explanation, transportation resources) and relationship/social histories. For children and adolescents this must include:
 - a. Prenatal and peri-natal events.
 - b. Complete developmental history.
 - c. Physical.
 - d. Psychological.
 - e. Social.
 - f. Intellectual.
 - g. Academic.
9. The record prominently notes the presence or absence of medications and other substances. If prescribed by the practitioner, notations must clearly indicate all dosages and dates of initial prescriptions and refills. Documentation includes medication education. Medication risks are noted/discussed with the member, such as risks of cert medications during pregnancy. Member is asked if there are barriers to taking medications as prescribed and these are discussed/documentated.
10. The record prominently identifies relevant, revised medical conditions.
11. The record documents PCP communication in the treatment record after initial evaluation.

12. The record prominently notes the presence or absence of allergies and sensitivities to pharmaceuticals and other substances.

Problem Formulation

1. The documentation includes a DSM-5 (five axes) diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
2. The documentation makes clear the relationship between the diagnoses/case formulation and the service plan.
3. Schedule a follow-up appointment after the initial evaluation.
4. Include the following in the service plan:
 - a. Objective measurable goals.
 - b. Estimated time frames for goal attainment or problem resolution.
 - c. Evidence of member understanding (for children this includes families).
 - d. Specific informed consent for somatotherapies including medication.
 - e. Updates as clinically appropriate.

Treatment

1. Treatment interventions are consistent with service plan objectives.
2. A strength-based individualized treatment plan, consistent with member's diagnosis, advances in his or her individualized recovery plan, and is reflective of the member's language and culture (real-life goals in all life domains).
3. Target symptoms/functional impairments to be addressed.
4. The treatment record includes a preliminary discharge plan.
5. The progress notes describe the member's strengths and limitations in achieving service plan objectives. The notes should include environmental factors that support change to avert the need for more intensive treatment or recidivism to present level of care as well as factors that may serve as obstacles to progress.
6. The treatment record documents the utilization of resources outside the therapeutic encounters including appropriate preventive services such as relapse prevention strategies, lifestyle changes, stress management, wellness programs and referrals to community resources.
7. All concurrent relevant caregivers—such as consultants, PCPs, ancillary practitioners, and health care institutions—and service delivery systems are contacted or involved in treatment, or if none, so noted, and evidence of continuity and coordination of care.
8. Documented dates of subsequent appointments at each contact, as well as, when appropriate, a discharge plan that includes:
 - a. Final five axis DSM-5 diagnosis.
 - b. Discharge summary (including goal achievement).
 - c. Discharge instructions.
 - d. Dates of follow-up appointments (time, date, and provider) documented.

- e. Individualized crisis plan indicating specific community-based options for crisis resolution.