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

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

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

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

Beacon uses the most current version of the New York state Office of Alcoholism and Substance Abuse Services (OASAS) Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) to determine medical necessity for all levels of substance use for Commercial, Medicaid, FIDA and Dually Eligible members when treatment is provided within New York State. When treatment is provided outside of New York State and for all other lines of business, the American Society of Addiction Medicine (ASAM) is utilized.

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

Note that NMNC stands for National Medical Necessity Criteria.
SECTION I: INPATIENT BEHAVIORAL HEALTH

Overview

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

A. NMNC 1.101.04 Inpatient Psychiatric Services (Adult/Adolescent/Child)

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

A. NMNC 1.101.04 Inpatient Psychiatric Services (Adult/Adolescent/Child)

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

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<thead>
<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
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<tbody>
<tr>
<td>Criteria 1 – 4 must be met and either 5 or 6 must be met; criteria 7, 8 or 9 must be met as applicable to a member’s unique condition; for Eating Disorders, criteria 10 – 13 must also be met in addition to the preceding criteria requirements</td>
<td>Criteria 1 – 10 must be met; for Eating Disorders, criterion 11 or 12 must also be met in addition to the preceding criteria requirements</td>
<td>Any one of the following criteria must be met: 1, 2, 3, 4 or 5; criteria 6 and 7 are recommended, but optional; for Eating Disorders, criteria 8 – 10 must be met</td>
</tr>
</tbody>
</table>

1) Symptoms consistent with a DSM or corresponding ICD Diagnosis; and
2) Member’s psychiatric condition requires 24-hour medical/psychiatric and nursing services and is of such intensity that needed services can only be provided in an acute psychiatric hospital; and;
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<td>3)</td>
<td>Inpatient psychiatric services are expected to significantly improve the member’s psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical/psychiatric and nursing services will no longer be needed; and;</td>
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<td>4)</td>
<td>Symptoms do not result from a medical condition that would be more appropriately treated on a medical/surgical unit; and;</td>
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<td>5) Danger to self <em>(one of the following)</em></td>
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<td>a) a serious suicide attempt by degree of lethality and intentionality; suicidal ideation with plan and means; and/or history of prior serious suicide attempt; or</td>
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<td></td>
<td>b) suicidal ideation accompanied by severely depressed mood, significant losses, and/or continued intent to harm self; or</td>
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<td>c) command hallucinations or persecutory delusions directing self-harm; or</td>
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<td>d) loss of impulse control resulting in life-threatening behavior or danger to self; or</td>
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<td>e) significant weight loss within the past three months; or</td>
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<td>f) self-mutilation that could lead to permanent disability; or</td>
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<td>g) uncontrolled risk-taking behaviors or</td>
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<tr>
<td>6) Danger to others: Homicidal ideation and/or indication of actual or potential danger to others <em>(one of the following)</em></td>
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<tr>
<td></td>
<td>a) command hallucinations or persecutory delusions directing harm or potential violence to others; or</td>
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<td></td>
<td>b) indication of danger to property evidenced by credible threats of destructive acts; or</td>
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<td></td>
<td>c) documented or recent history of violent, dangerous, and destructive acts would likely require rapid re-hospitalization;</td>
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<tr>
<td>4)</td>
<td>Treatment is still necessary to reduce symptoms and improve functioning so that the member may be treated in a less restrictive Level of Care.</td>
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<tr>
<td>5)</td>
<td>There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment continuing in a less restrictive Level of Care;</td>
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<tr>
<td>6)</td>
<td>Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. Treatment plan has been updated to address non-adherence.</td>
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<tr>
<td>7)</td>
<td>The member is actively participating in plan of care and treatment to the extent possible consistent with his/her condition</td>
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<tr>
<td>8)</td>
<td>Family/guardian/caregiver is participating in treatment as appropriate.</td>
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<tr>
<td>9)</td>
<td>There is documentation of coordination of treatment with state or other community agencies, if involved.</td>
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<tr>
<td>10)</td>
<td>Coordination of care and active discharge planning are ongoing, beginning at admission, with goal of transitioning the member to a less intensive Level of Care.</td>
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</table>

**For Eating Disorders:**

| 8) | Member has reached at least 85% ideal body weight and has gained enough weight to achieve medical stability (e.g., vital signs, electrolytes, and electrocardiogram are stable). |
| 9) | No re-feeding is necessary |
| 10) | All other psychiatric disorders are stable (do not require this level of care) |
7) Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning:
8) Evidence of severe disorders of cognition, memory, or judgment are not associated with a primary diagnosis of neurocognitive disorder (dementia) or other cognitive disorder. (e.g. acute psychotic symptoms
9) Severe comorbid substance use disorder is present and must be controlled (e.g. abstinence necessary) to achieve stabilization of primary psychiatric disorder

For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge

10) DSM/ICD diagnosis and symptoms consistent with a primary diagnosis of Eating Disorder
11) Member has at least one of the following:
   a) Psychiatric, behavioral, and eating disorder symptoms that are expected to respond to treatment in an Acute Level of Care; or
   b) Symptomatology that is not responsive to treatment in a less intensive Level of Care; or
   c) An adolescent with newly diagnosed anorexia;
12) Member requires 24-hour monitoring, which includes: before, after, and during meals; evening to monitor behaviors (i.e. restricting, binging/purging, over-exercising, use of laxatives or diuretics);
13) Member exhibits physiological instability requiring 24-hour monitoring for at least one (1) of the following:
   a) Rapid, life-threatening and volitional weight loss not related to a medical illness: generally, <80% of IBW (or BMI of 15 or less. Electrolyte imbalance ); or
b) Physiological liability (i.e. Significant postural hypotension, bradycardia, CHF, cardiac arrhythmia); or
c) Change in mental status; or
d) Body temperature below 96.8 degrees; or
e) Severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement; or
f) Acute gastrointestinal dysfunction (i.e. Esophageal tear secondary to vomiting, mega colon or colonic damage, due to self-administered enemas); or
g) Heart rate is less than 40 beats per minute for adults or near 40 beats per minute for children

Exclusions

Any one of the following criteria is sufficient for exclusion from this level of care

1) Member can be safely maintained and effectively treated at a less intensive level of care; or
2) Symptoms result from a medical condition which warrants a medical / surgical setting for treatment; or
3) Member exhibits serious and persistent mental illness and is not in an acute exacerbation of the illness; or
4) The primary problem is social, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
Reference sources
Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:
1. Professional societies: American Psychiatric Association (APA)
2. National care guideline and criteria entities: MCG Care Guidelines
3. National health institutes: National Institutes of Health (NIH)
4. Professional publications and psychiatric texts: [Beacon’s Publication Reference Table]
5. Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6. National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)

Inpatient Substance Use Disorder Services –
Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Hospital Based Inpatient Detoxification is defined as medically managed withdrawal and stabilization in a hospital setting certified as an Article 28 by the Department of Health and Medically Managed Withdrawal Services by OASAS. Medically managed withdrawal and stabilization services are designed for individuals who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid conditions. This level of care includes the 48-hour observation bed. Individuals who have stabilized in a medically managed detoxification service may step-down to a medically supervised service within the same service setting or may be transferred to another service setting.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Hospital Based Inpatient Detoxification LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM Level 4, Medically Managed Intensive Inpatient Withdrawal Management.

Acute Substance Use Disorders Treatment –
Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Medically Supervised Inpatient Detoxification is defined as a service that provides treatment of moderate withdrawal symptoms and non-acute physical or psychiatric complications. This service is physician directed and staffed 24 hours a day 7 days per week with medical staff and included 24-hour emergency medical coverage. Medically supervised withdrawal services provide: bio-psycho-social assessment, medical supervision of intoxication and withdrawal conditions; pharmacological services; individual and group counseling; level of care determination; and referral to other appropriate services. Medically supervised withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are experiencing
or who are expected to experience withdrawal symptoms that require medical oversight. Individuals who have stabilized in a medically managed or medically supervised inpatient withdrawal service may step-down to a medically supervised outpatient service.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Medically Supervised Inpatient Detoxification LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM level 3.7, Medically Monitored Inpatient Withdrawal Management Services.

Per the OASAS LOCADTR 3.0 Manual (Adult) Inpatient Rehabilitation is defined as an OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility. Medical coverage and individualized treatment services are provided to individuals with substance use disorders who are not in need of medical detoxification or acute care and are unable to participate in, or comply with, treatment outside of a 24-hour structured treatment setting. Individuals may have mental or physical complications or comorbidities that require medical management or may have social, emotional or developmental barriers to participation in treatment outside of this setting. Treatment is provided under direction of a physician medical director and the staff includes nursing and clinical staff 24 hours 7 days per week. Activities are structured daily to improve cognitive and behavioral patterns and improve functioning to allow for the development of skills to manage chronic patterns of substance use and develop skills to cope with emotions and stress without return to substance use. People who are appropriate for inpatient care have co-occurring medical or psychiatric conditions or who are using substance in a way that puts them in harm. Many experience decreases in ability to reason and have impaired judgment that interfere with decision making, risk assessment and goal setting and need a period of time for these consequence of substance use to diminish.

Per the OASAS LOCADTR 3.0 Manual (Adolescent) – Individuals under 21 have two options for in-patient services Part 816 – Inpatient services as described above or Part 817 Residential Rehabilitation Services for Youth (RRSY), which includes a person centered approach for individuals under 21 years of age; program is designed specifically to serve chemically dependent individuals who are under the age of 21. The RRSY program will provide active treatment, including structured therapeutic activities, as well as clinical, recovery support, medical, vocational, case management, educational and recreation services. The goals of an RRSY include the promotion and maintenance of abstinence from alcohol and other mood-altering drugs or substances except those prescribed by a physician, physician’s assistant, or nurse practitioner; the improvement of functioning and development of coping skills necessary to enable the patient to be safely, adequately and responsibly treated in the least intensive environment; and the development of individualized plans to support the maintenance of recovery, attain self-sufficiency, and improve the patient’s quality of life. Access to 24 hour clinical and medical staff. This level of care is available for the under 21 year old population as both an inpatient alternative and as an option of for Residential Substance Use Disorder Treatment.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Inpatient Rehabilitation LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM level 3.7, Medically Monitored Intensive Inpatient Services.
SECTION II: DIVERSIONARY SERVICES

Overview

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

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

A. Ambulatory Detoxification
B. NMNC 3.301.03 Partial Hospitalization Program and Outpatient Day Rehabilitation
C. NMNC 3.302.03 Intensive Outpatient Treatment (Adult/Adolescent/Child)
D. Continuing Day Treatment (Minimum age is 18)
E. Intensive Psychiatric Rehabilitation Treatment (IPRT)
F. NMNC 2.202.04 Residential Treatment Service (RTS) (Adult/Adolescent/Child)

A. Ambulatory Detoxification

Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Ancillary Withdrawal Services are defined as services that are the medical management of mild or moderate symptoms of withdrawal within in an OASAS-certified setting. Medical staff monitor withdrawal symptoms. Providers must have a protocol for providing ancillary withdrawal services approved by the OASAS Medical Director. The protocol must include a physician director of the service, medication and counseling protocol for managing withdrawal and 24-hour emergency plan. Staffing will include a physician, physician extenders, registered nurse, clinical staff. Treatment plan will include the medication protocol to achieve safe withdrawal management, clinical interventions to provide engagement, management of urges and cravings, addresses cognitive and behavioral issues and recovery supports.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Ancillary Withdrawal Services LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM Level 1-Ambulatory Withdrawal Management and Level 2- Ambulatory Withdrawal Management Criteria.

B. NMNC 3.301.03 Partial Hospitalization Program (Adult/Adolescent/Child)
Partial Hospitalization Programs (PHP) are short-term day programs consisting of intensive, acute, active treatment in a therapeutic milieu equivalent to the intensity of services provided in an inpatient setting. These programs must be available at least 5 days per week, though may also be available seven days per week, typically 6 to 8 hours per day. The short-term nature of an acute PHP makes it inappropriate for long-term day treatment. A PHP requires psychiatric oversight with at least weekly medication management as well as highly structured treatment. The treatment declines in intensity and frequency as a member establishes community supports and resumes normal daily activities. A partial hospitalization program may be provided in either a hospital-based or community based location. Members at this level of care are often experiencing symptoms of such intensity that they are unable to be safely treated in a less intensive setting, and would otherwise require admission to an inpatient level of care. Children and adolescents participating in a partial hospital program must have a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on family, community supports, and school, the PHP consults with the caretakers and the child's programs as needed to implement behavior plans, or participate in the monitoring or administration of medications.

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<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
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<tbody>
<tr>
<td>Criteria 1 – 8 must be met; for Eating Disorders, criteria 9 – 10 must also be met in addition to the first eight.</td>
<td>Criteria 1 – 8 must be met; for Eating Disorders, criteria 9 or 10 must also be met in addition to the first eight.</td>
<td>Any one of the following must be met:</td>
</tr>
<tr>
<td>1) Symptoms consistent with a DSM or corresponding ICD diagnosis that requires, and can reasonably be expected to respond to, treatment interventions</td>
<td>1) Member continues to meet admission criteria</td>
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<tr>
<td>2) The member manifests an acute and significant or profound impairment in daily functioning due to psychiatric illness.</td>
<td>2) Another less intensive level of care would not be adequate to administer care.</td>
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<tr>
<td>3) Member has adequate behavioral control and is assessed not to be an immediate danger to self or others requiring 24-hour containment or medical supervision.</td>
<td>3) Treatment is still necessary to reduce symptoms and increase functioning so the member may be treated in a less intensive level of care.</td>
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<tr>
<td>4) Member has a community-based network of support and/or parents/caretakers who are able to ensure member’s safety outside the treatment hours.</td>
<td>4) There is an individualized treatment plan that is focused on addressing the factors leading to admission and evidence suggests that the identified problems are likely to respond to current treatment plan</td>
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<td>5) Member requires access to an intensive structured treatment program with an on-site multidisciplinary team, including routine</td>
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CMMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19
<table>
<thead>
<tr>
<th>Level of Care Criteria</th>
<th>For Eating Disorders</th>
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<tr>
<td>6) Member can reliably attend and actively participate in all phases of the treatment program necessary to stabilize his or her condition.</td>
<td>6) Member has gained weight, or is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care.</td>
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<tr>
<td>7) The severity of the presenting symptoms is not able to be treated safely or adequately in a less intensive level of care.</td>
<td>7) Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway.</td>
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<tr>
<td>8) Member has adequate motivation to recover in the structure of an ambulatory treatment program.</td>
<td>8) Coordination of care and active discharge planning are ongoing, with goal of transitioning member to a less intensive Level of Care.</td>
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**For Eating Disorders:**

- * weight alone should not be the sole criteria for admission or discharge

9) Member exhibits symptoms consistent with an eating disorder diagnosis and requires **at least one** of the following:

a) as a result of eating disorder behaviors, weight stabilization: generally, between 80 and 85% of IBW (or BMI 15-17) is needed*; or

b) frequent supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight loss behavior, such as caloric restriction, intake refusal, voluntary vomiting or excessive exercise; or

c) Member misuse of pharmaceuticals with an intent to control weight (e.g., laxatives, diuretics, stimulants) cannot be treated at a lower level of care.

10) Medical comorbidity or medical complications resulting from the eating disorder are absent or manageable and do not require 24-hour medical monitoring or procedures provided in a hospital level of care.

5) Member’s progress is monitored regularly, the treatment plan is modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals.

6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.

7) Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway.

8) Coordination of care and active discharge planning are ongoing, with goal of transitioning member to a less intensive Level of Care.

**For Eating Disorders:**

- * weight alone should not be the sole criteria for admission or discharge

9) Member has had no appreciable stabilization of weight since admission; or there is continued instability in food intake despite weight gain; or

10) The eating disorder behaviors persist and continue to put the member’s medical status in jeopardy.
Exclusions

Any one of the following criteria are sufficient for exclusion from this level of care:

1) Member is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required; or.
2) Member can be safely maintained and effectively treated at a less intensive level of care; or.
3) Member or guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment; or
4) Member requires a level of structure and supervision beyond the scope of the program; or
5) Member has medical conditions or impairments that would prevent beneficial utilization of services; or
6) Primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration

Reference Sources
Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)
4) Professional publications and psychiatric texts: [see Beacon's Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)

Partial Hospitalization Substance Use Disorder Services and Outpatient Day Rehabilitation

Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Outpatient Rehabilitation is defined as OASAS-certified services designed to assist individuals with chronic medical and psychiatric conditions. These programs provide: social and health care services; skill development in accessing community services; activity therapies; information and education about nutritional requirements; and vocational and educational evaluation. Individuals initially receive these procedures three to five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services and a half-time nurse practitioner, physician's assistant, or registered nurse. Like medically supervised outpatient, outpatient rehabilitation services require a physician medical director and medical staff are part of the multi-disciplinary team. The clinical team includes credentialed alcohol and substance abuse counselors and other qualified health professionals. A treatment plan is required to address functional needs of the individual including cognitive, behavioral, employment, and interpersonal.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Outpatient Rehabilitation LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM Criteria Level 2.5, Partial Hospitalization Services.

C. NMNC 3.302.03 Intensive Outpatient Treatment (Adult/Adolescent/Child)

Intensive Outpatient Programs (IOP) offer short-term, multidisciplinary, structured day or evening programming that consists of intensive treatment and stabilization within an outpatient therapeutic milieu setting. IOP must be available at least three to five days a week, typically 2-3 hours per day Treatment reduces in intensity and frequency as the member establishes community supports and resumes daily activities. The short-term nature of IOPs makes it inappropriate to meet the need for long-term day treatment. IOPs may be provided by either hospital-based or freestanding outpatient programs to members who experience symptoms of such intensity that they are unable to be safely treated in a less intensive setting and would otherwise require admission to a more intensive level of care. These programs also include 24/7 crisis management services, individual, group, and family therapy and coordination of medication evaluation and management services, as needed. Coordination with collateral contacts and care management/discharge planning services should also occur regularly as needed in an IOP. For children and adolescents, the IOP provides services similar to an acute level of care for those members with a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child’s caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

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<tr>
<th>Admission Criteria</th>
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</table>
### All of the following criteria 1 – 7 must be met; for Eating Disorders criteria, 8 – 10 must also be met in addition to the preceding seven

1) Symptoms consistent with a DSM or corresponding ICD diagnosis.
2) Member is determined to have the capacity and willingness to improve or stabilize as a result of treatment at this level.
3) Member has significant impairment in daily functioning due to psychiatric symptoms or comorbid substance use of such intensity that member cannot be managed in routine outpatient or lower level of care;
4) Member is assessed to be at risk of requiring a higher level of care if not engaged in intensive outpatient treatment;
5) There is indication that the member’s psychiatric symptoms will improve within a reasonable time period so that the member can transition to outpatient or community based services;
6) Member’s living environment offers enough stability to support intensive outpatient treatment.
7) Member’s psychiatric/substance use/biomedical condition is sufficiently stable to be managed in an intensive outpatient setting.

### For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge

### All of the following criteria must be met; for Eating Disorders, criteria 11 or 12 must also be met in addition to the first 10

1) Member continues to meet admission criteria.
2) Another less intensive level of care would not be adequate to administer care;
3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely require a more intensive level of care.
4) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less intensive level of care;
5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.
6) There is an individualized treatment plan that is focused on addressing the factors leading to admission and evidence suggests that the identified problems are likely to respond to current treatment plan.
7) Member’s progress is monitored regularly. The treatment plan is modified, if the member is not making substantial progress towards clearly defined and measurable goals.
8) Family/guardian/caregiver is participating in treatment as appropriate.
9) There is documentation around coordination of treatment with collaterals and other providers when appropriate.

### Any one of the following criteria must be met

1) Member no longer meet admission criteria and/or meets criteria for another level of care, either more or less intensive; or
2) Parent or guardian withdraws consent for treatment or the Member is unwilling or unable to participate in treatment, and involuntary treatment or guardianship is not being pursued; or
3) Member does not appear to be participating in the treatment plan despite multiple documented efforts to engage the member; or
4) Member is not making progress toward goals, nor is there expectation of any progress.
5) Member’s individual treatment plan and goals have been met and when indicated, member’s support systems are in agreement with the aftercare treatment plan; or

**For Eating Disorders**

6) Member has gained weight, or is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care.
8) Any monitoring of member’s condition when away from intensive outpatient program can be provided by family, caregivers, or other available resources
9) Member exhibits symptoms consistent with an eating disorder diagnosis and requires at least one of the following:
   a) as a result of eating disorder behaviors, weight stabilization: generally, between 80 and 85% of IBW (or BMI 15-17) is needed*; or
   b) frequent supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight loss behavior such as caloric restriction, intake refusal, voluntary vomiting or excessive exercise; or
   c) Member misuse of pharmaceuticals with an intent to control weight (e.g., laxatives, diuretics, stimulants) cannot be treated at a lower level of care.
10) Medical comorbidity or medical complications resulting from the eating disorder are absent or manageable and do not require medical intervention in a higher level of care

**Exclusions**

*Any one of the following criteria is sufficient for exclusion from this level of care:*

1) Member is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required; or
2) Member can be safely maintained and effectively treated at a less intensive level of care; or

10) Provider has documentation supporting discharge-planning attempts to transition the member to a less intensive level of care for Eating Disorders*

11) Member has had no appreciable stabilization of weight since admission or there is continued instability in food intake despite weight gain; or
12) The eating disorder behaviors persist and continue to put the member’s medical status in jeopardy
3) Member or guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment.
4) Member requires a level of structure and supervision beyond the scope of the program; or
5) Member has medical conditions or impairments that would prevent beneficial utilization of services; or
6) Primary problem is social, custodial, economic (i.e., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration; or
7) Main purpose of the admission is to provide structure that may otherwise be achieved via community-based or other services to augment vocational, therapeutic or social activities; or
8) Treatment plan is designed to address goals other than the treatment of active symptoms consistent with a DSM or corresponding ICD diagnosis (e.g., self-actualization).

**Reference Sources**
Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)
4) Professional publications and psychiatric texts: [see Beacon’s Publication Reference Table](#)
5) Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)
Intensive Outpatient Substance Use Disorder Services –

Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Intensive Outpatient Services are defined as an OASAS-certified treatment service provided by a team of clinical staff for individuals who require a time-limited, multi-faceted array of services, structure, and support to achieve and sustain recovery. Intensive outpatient treatment programs schedule a minimum of 9 service hours per week delivered during the day, evening or weekends. This service is provided in a certified outpatient clinic under the direction of a physician medical director. A team of clinical and medical staff must provide this service including credentialed alcohol and substance abuse counselors and other qualified health professionals. The treatment program consists of, but is not limited to: individual, group and family counseling; relapse prevention and cognitive and behavioral interventions; motivational enhancement; and the development of coping skills to effectively deal with emotions and environmental stressors.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Intensive Outpatient LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM Level 2.1, Intensive Outpatient Services.

D. Continuing Day Treatment (Minimum age is 18)

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

<table>
<thead>
<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
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<tbody>
<tr>
<td><strong>All of the following criteria 1 – 7 must be met:</strong></td>
<td><strong>All of the following criteria 1 – 6 must be met:</strong></td>
<td><strong>Any one of the following:</strong></td>
</tr>
<tr>
<td>1) Symptoms consistent with a DSM or ICD diagnosis.</td>
<td>1) Member continues to meet admission criteria.</td>
<td>Criteria 1, 2, 3, or 4; criteria 5 – 6 are recommended, but optional:</td>
</tr>
<tr>
<td>2) Member’s exacerbation or longstanding psychiatric disorder and level of functioning requires daily support and structure;</td>
<td>2) Another less intensive level of care would not be adequate to administer care.</td>
<td>1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive.</td>
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<tr>
<td>3) The member has the motivation and capacity to participate and benefit from day treatment.</td>
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LEVEL OF CARE CRITERIA- NEW YORK

CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19
4) Treatment at a less intensive level of care would contribute to an exacerbation of symptoms.
5) Member is assessed to be at risk of requiring a higher level of care if not engaged in day treatment services.
6) Member/guardian is willing to participate in treatment voluntarily
7) Member’s psychiatric/substance use/biomedical condition is sufficiently stable to be managed in a day treatment setting.

**Exclusions**

*Any of the following criteria are sufficient for exclusion from this level of care:*

1) The individual is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required.
2) The individual can be safely maintained and effectively treated at a less intensive level of care.
3) The individual does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment.
4) The individual requires a level of structure and supervision beyond the scope of the program.
5) The individual has medical conditions or impairments that would prevent beneficial utilization of services.
6) The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.

| 2) Member or guardian withdraws consent for treatment. |
| 3) Member does not appear to be participating in the treatment plan. |
| 4) Member is not making progress toward goals, nor is there expectation of any progress. |
| 5) Member’s individual treatment plan and goals have been met. |
| 6) Member’s support system is in agreement with the aftercare treatment plan. |

3) Treatment is still necessary to reduce symptoms and increase functioning for the member to be transitioned to a less restrictive setting.
4) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.
5) Family/guardian is participating in treatment as clinically indicated.
6) Coordination of care and active discharge planning are ongoing.

### E. Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

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

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<tr>
<th>Admission Criteria</th>
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<tbody>
<tr>
<td>All of the following criteria 1 – 4 must be met:</td>
<td>All of the following criteria 1 – 2 must be met:</td>
<td>Any one of the following: Criteria 1, 2, 3, 4, 5, or 6:</td>
</tr>
<tr>
<td>1) DSM or corresponding ICD diagnosis</td>
<td>1) The member continues to meet admission criteria</td>
<td>1) The member no longer meets PRS level-of-care criteria.</td>
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<tr>
<td>2) Member has adequate capacity to participate in and benefit from this treatment.</td>
<td>2) One of the following is present:</td>
<td>2) The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated.</td>
</tr>
<tr>
<td>3) Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care</td>
<td>a) The member has an active goal and shows progress toward achieving it.</td>
<td>3) The member has achieved current recovery goals and can identify no other goals that would require additional IPRT services in order to achieve those goals.</td>
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<tr>
<td>4) Member is assessed to be at risk of requiring higher levels of care if not engaged in IPRT treatment.</td>
<td>b) The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas.</td>
<td>4) The member is not participating in a recovery plan and is not making progress toward any goals.</td>
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<td>c) The member requires an IPRT level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without IPRT services; and the individual would require a higher level of care.</td>
<td>5) Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation.</td>
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<td>6) The member can live, learn, work and socialize in the community with supports from natural and/or community resources.</td>
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F. NMNC 2.202.04 Residential Treatment Services (Adult/Adolescent/Child)

Residential Treatment Services (also known as a Residential Treatment Center) are 24-hour, seven-days a week facility-based programs that provide therapeutic intervention and specialized programming, such as group, CBT, DBT and motivational interviewing, for members with severe and persistent psychiatric disorders. While the setting provides a high degree of supervision and structure, RTS is intended for members who do not require an even higher level of physical security and frequency of psychiatric or medical intervention that are available on an inpatient unit. In addition, the program provides individualized therapeutic treatment. RTS is not an equivalent for long-term hospital care. Rather, its design is to maintain the member in a less restrictive environment that promotes stabilization and integration of clinical gains. Consultations and psychological testing, as well as routine medical care, are included in the per diem rate. Realistic discharge goals should be set upon admission, including
coordination with community-based treatment providers, as appropriate. Physician evaluation and re-evaluations are based on each individual member’s clinical needs.

<table>
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<th>Discharge Criteria</th>
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<tr>
<td>Criteria 1 – 9 must be met for all admissions; criterion 10 must be met when applicable; for Eating Disorders, criteria 11 – 15 must also be met in addition to the preceding requirements</td>
<td>Criteria 1 – 11 must be met for all continued stays; for Eating Disorders, criteria 12 and 13 must also be met in addition to the preceding requirements</td>
<td>Any one of the following criteria must be met</td>
</tr>
<tr>
<td>1) Systems consistent with a DSM or corresponding ICD diagnosis representing a behavioral disorder that requires, and can reasonably be expected to respond to therapeutic interventions</td>
<td>1) Member continues to meet admission criteria;</td>
<td>1) Member no longer meets admission criteria and/or meets criteria for another level of care, more or less intensive; or</td>
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<tr>
<td>2) Member is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic setting and does not require a higher level of care (inpatient).</td>
<td>2) Another less restrictive level of care would not be adequate to provide needed containment and administration of care.</td>
<td>2) Member or parent/guardian withdraws consent for treatment and the member does not meet criteria for involuntary/mandated treatment; or</td>
</tr>
<tr>
<td>3) The member may not be appropriate for a less intensive level of care as evidenced by a series of increasingly dangerous behaviors which present significant risk to self or others</td>
<td>3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely be readmitted;</td>
<td>3) Member does not appear to be participating in the treatment plan; or</td>
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<tr>
<td>4) Member has sufficient cognitive capacity to respond to active, intensive and time-limited behavioral health treatment and intervention.</td>
<td>4) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive level of care.</td>
<td>4) Member is not making progress toward goals, nor is there expectation of any progress.</td>
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<tr>
<td>5) Member has Severe in ability to perform self-care activity (i.e. self-neglect with inability to provide for self at a lower level of care).</td>
<td>5) There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care.</td>
<td>5) Member’s individual treatment plan and goals have been met. and when indicated Member’s support system is in agreement with the aftercare treatment plan; or</td>
</tr>
<tr>
<td>6) Member has only poor to fair community supports sufficient to maintain him/her within the community with treatment at a lower level of care.</td>
<td>6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out</td>
<td>For Eating Disorders:</td>
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<td>7) Member evaluation by physician occurs on an at least weekly basis</td>
<td>6) Member has gained weight, is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care.</td>
</tr>
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</table>
7) Member requires a time-limited period for stabilization and community reintegration.
8) When appropriate, family/guardian/caregiver agree to participate actively in treatment as a condition of admission.
9) Member’s behavior or symptoms, as evidenced by the initial assessment and treatment plan, are likely to respond to or are responding to active treatment.
10) Severe comorbid substance use disorder is present that must be controlled (e.g., abstinence necessary) to achieve stabilization of primary psychiatric disorder.

**For Eating Disorders:** *weight alone should not be the sole criteria for admission or discharge*

11) Weight stabilization: generally, <85% of IBW (or BMI of 15 or less, with no significant co-existing medical conditions
12) Member is medically stable and does not require IV fluids, tube feedings or daily lab tests.
13) Member has had a recent significant weight loss and cannot be stabilized in a less restrictive level of care.
14) Member needs direct supervision at all meals and may require bathroom supervision for a time period after each meal.
15) The member is unable to control obsessive thoughts or reduce negative behaviors (e.g. restrictive eating, purging, laxative or diet pill abuse, and/or excessive exercising) in a less restrictive environment.

9) Member is engaged in treatment and amenable to goals/interventions set forth by treatment team.
10) Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate or engagement is underway.
11) There must be evidence of coordination of care and active discharge planning to:
   a) Transition the member to a less intensive level of care; and
   b) Operationalize how treatment gains will be transferred to subsequent level of care.

**For Eating Disorders:**

12) Member continues to need supervision for most if not all meals and/or use of bathroom after meals.
13) Member has had no appreciable weight gain since admission.
Exclusions:

Any one of the following criteria is sufficient for exclusion from this level of care:

1) Member exhibits severe suicidal, homicidal or acute mood symptoms/thought disorder, which requires a more intensive level of care; or
2) Member does not voluntarily consent to admission or treatment; or
3) Member can be safely maintained and effectively treated at a less intensive level of care; or
4) Member has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications; or
5) Primary problem is social, legal, and economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as custodial care or as an alternative to incarceration.

For Eating Disorders*, member’s IBW is < 75% (or BMI of 14 or less)

Reference Sources

Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)
4) Professional publications and psychiatric texts: [see Beacon’s Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)
Residential Treatment Services Substance Use Disorder –

Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Stabilization Services in a Residential Setting are OASAS-certified providers of residential programs that also provide medical and clinical services including: medical evaluation; ongoing medication management and limited medical intervention; ancillary withdrawal and medication assisted substance use treatment; psychiatric evaluation and ongoing management; and group, individual and family counseling focused on stabilizing the individual and increasing coping skills until the individual is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the safety of the residence. This service has a physician who serves as medical director, psychiatrist, nurse practitioner and/or physician assistants to provide and oversee medical and psychiatric treatment. Medical staff are available in the residence daily, but 24-hour medical/nursing services are not. There is medical staff available on call 24/7 and there are admitting hours 7 days per week.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Stabilization Services in a Residential Setting LOCADTR criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM Criteria Level 3.5, Clinically Managed High-Intensity Residential Services.

Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescents 18 years of age and older) Rehabilitation Services in a Residential Setting are Certified OASAS providers of residential programs that also provide rehabilitative services for individuals who are stable enough to manage emotional states, urges and cravings, co-occurring psychiatric symptoms and medical conditions within the safety of a residential setting. This service requires a physician who will serve as medical director, nurse practitioner, psychiatrist and nursing staff on site daily and clinical staff provide monitoring for medical and psychiatric symptoms that are stable. Services include medical monitoring of chronic conditions including routine medication management and individual, group and family counseling focused on rehabilitation. The service requires a treatment plan to address functional needs including personal and interpersonal functioning. The treatment program teaches individuals to manage self and interactions with others with increasing independence.

Per the OASAS LOCADTR 3.0 Manual (Adolescent) RRSY (817) (Residential Rehabilitation Services for Youth) program is designed specifically to serve chemically dependent individuals who are under the age of 21. The RRSY program will provide active treatment, including structured therapeutic activities, as well as clinical, recovery support, medical, vocational, case management, educational and recreation services. The goals of an RRSY include the promotion and maintenance of abstinence from alcohol and other mood-altering drugs or substances except those prescribed by a physician, physician’s assistant, or nurse practitioner; the improvement of functioning and development of coping skills necessary to enable the patient to be safely, adequately and responsibly treated in the least intensive environment; and the development of individualized plans to support the maintenance of recovery, attain self-sufficiency, and improve the patient’s quality of life.

For Commercial, Medicaid, FIDA and Dually Eligible members, please refer to the OASAS Rehabilitation Services in a Residential Setting LOCADTR Criteria. For all other lines of business, see ASAM Level 3.3, Clinically Managed Population- specific High-Intensity Residential Services.
Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Reintegration in a Residential Settings are Certified OASAS providers of residential programs that also provide reintegration services to transition from structured treatment environments to more independent living. This setting does not require a physician to serve as medical director and staff coordinate treatment services but do not provide direct clinical care. Most services are provided in the community and include clinical and social services. Individuals are provided a safe living environment with a high degree of behavioral accountability. Services include medical and clinical oversight of chronic but stable medical and psychiatric symptoms and conditions in a community treatment program including an outpatient Substance Use Disorder treatment program. Services also include: community meetings; activities of daily living (ADL) support; case management; and vocational support and clinical services to support transition to independent living.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Reintegration in a Residential Setting LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM Level 3.1, Clinically Managed Low-Intensity Residential Services.

**SECTION III: EMERGENCY SERVICES**

**Overview**

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

A. Emergency Screening/Crisis Evaluations

B. Comprehensive Psychiatric Emergency Program

C. Mobile Crisis Intervention

A. Emergency Screening/Crisis Evaluations

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

B. Comprehensive Psychiatric Emergency Program (CPEP)

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

**C. Mobile Crisis Intervention**

Mobile Crisis Intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified behavioral health diagnosis. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis. There is no level of care criteria for Mobile Crisis Intervention.

**SECTION IV: OUTPATIENT BEHAVIORAL HEALTH SERVICES**

**Overview**

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

- **A. NMNC 5.501.03 Outpatient Professional Services (Adult/Adolescent/Child)**
- **B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)**
- **C. NMNC 6.604.04 Applied Behavioral Analysis (Adolescent/Child)**
- **D. Developmental Screening**
- **E. NMNC 5.502.04 Psychological and Neuropsychological Testing (Adult/Adolescent/Child)**
- **F. NMNC 5.503.02 Biofeedback (Adult/Adolescent/Child)**

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

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

A. NMNC 5.501.03 Outpatient Professional Services (Adult/Adolescent/Child)

Outpatient Behavioral Health treatment provides an essential service component within a comprehensive health care delivery system. Outpatient treatment benefits individuals with behavioral health conditions, chronic and acute medical illnesses, substance use disorders, family problems, and personal and interpersonal challenges. Treatment goals include restoration, enhancement, and/or maintenance of an individual’s level of functioning and the alleviation of disruptive symptoms. The goals, frequency, and length of treatment vary according to individual needs and symptomatology. Effectively designed interventions help individuals and families to recover quickly from setbacks and to cope with stressful life situations and challenges. Best practice includes: 1) routine use of a functional rating scale to inform progress and treatment adjustments; and 2) preparing the member with a plan for managing emergencies or escalating symptoms between treatment sessions, including after-hours resources, (e.g., availability of on-call service, community crisis intervention services). Providers may use approved telehealth services to address geographic and mobility access issues. Outpatient Professional Services do not require prior authorization.

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<th>Admission Criteria</th>
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<tr>
<td>All of the following criteria must be met:</td>
<td>All of the following criteria must be met:</td>
<td>Any one of the following criteria must be met:</td>
</tr>
<tr>
<td>1) Member demonstrates symptoms consistent with a DSM or corresponding ICD diagnosis, and treatment focus is to stabilize these symptoms; 2) Member must be experiencing at least one of the following: a) A chronic affective illness, schizophrenia, or a refractory behavioral disorder, which by history, has required hospitalization; or b) Moderate to severe symptomatic distress or impairment in functioning due to psychiatric symptoms in at least one area of functioning</td>
<td>1) Member continues to meet admission criteria. 2) Member does not require a more intensive level of care, and no less intensive level of care would be appropriate to meet the member’s needs. 3) Evidence suggests that the identified problems are likely to respond to current treatment plan; 4) Member’s progress is monitored regularly, informed by objective outcomes measurements that assess the member’s</td>
<td>1) The precipitating factors leading to admission have been resolved or ameliorated such that the member no longer needs care; or 2) Member has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others; or</td>
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LEVEL OF CARE CRITERIA- NEW YORK

CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19

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(i.e. self-care, occupational, school, or social function).

3) There is an expectation that the individual:
   a) Has the capacity to make significant progress towards treatment goals; or
   b) Requires treatment to maintain current level of functioning; or
   c) Has the ability to reasonably respond and participate in therapeutic intervention; or
   d) Would be at risk to regress and require a more intensive level of care

4) The member does not require a more intensive level of care beyond the scope of non-programmatic outpatient services.

5) Medication management is not sufficient to stabilize or maintain member’s current functioning;

6) The member is likely to benefit from and respond to psychotherapy due to diagnosis, history, or previous response to treatment;

7) Treatment is not solely being sought as an alternative to incarceration.

Exclusions

Any one of the following criteria are sufficient for exclusion from this level of care:

1) Member requires a level of structure and supervision beyond the scope of non-programmatic outpatient services; or

2) Member has medical conditions or impairments that would prevent beneficial utilization of services or

3) The primary problem is social, occupational, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration; or

response to treatment (for example, repeated use of a standardized functioning or symptom rating scale)

5) Treatment plan is individualized and modified as needed if the member is not making substantial progress toward a set of clearly defined and measurable goals

6) Treatment planning includes family or other support systems unless not clinically indicated

7) Frequency and intensity of treatment contact occurs at a rate that is appropriate to the severity of current symptoms (intermittent treatment allowing the member to function with maximal independence is the goal); and a lower frequency of sessions not would be sufficient to meet the member’s needs.

8) Evidence exists that member is at current risk of a higher level of care if treatment is discontinued.

9) When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner.

10) There is documented active discharge planning from the beginning of treatment.

3) Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care; or

4) Member has substantially met the specific goals outlined in treatment plan (there is resolution or acceptable reduction in target symptoms that necessitated treatment); or.

5) Member is competent and non-participatory in treatment, or the individual’s non-participation is of such degree that treatment at this level of care is rendered ineffective or unsafe despite multiple documented attempts to address non-participation issues; or

6) Evidence suggests that the member is not making progress toward the goals and the defined problems are unlikely to respond to continued outpatient treatment with the current treatment approach; or

7) Current treatment plan is not sufficiently goal oriented and focused to meet behavioral objectives; or

8) Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for inpatient level of care; or
4) Treatment plan is designed to address goals other than the treatment of active symptoms consistent with a DSM or corresponding ICD diagnosis (e.g. self-actualization); or
5) Rehabilitative or community services are provided and are adequate to stabilize or assist the individual in resuming prior level of roles and responsibility; or
6) Treatment is primarily for the purpose of supportive, respite, social, custodial care.

Reference Sources
Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:
1) Professional societies: American Psychiatric Association (APA); American Academy of Psychiatricists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)
4) Professional publications and psychiatric texts: [see Beacon’s Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)

Substance Use Outpatient Services –
Per the OASAS LOCADTR 3.0 Manual (Adult and Adolescent) Outpatient Clinic services are defined as OASAS-certified outpatient services having multi-disciplinary teams that include medical staff and a physician who serves as medical director. These programs provide treatment services to individuals who suffer from substance use disorders and their family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the patient. The length of stay and the intensity (as measured by frequency and duration of visits) will vary during the course of treatment. In general, persons are engaged in more frequent outpatient treatment visits earlier in the treatment process; visits generally become less frequent as treatment progresses. Treatment includes the following procedures: group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disorder awareness and relapse prevention; HIV and other communicable disease education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional
requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan.

Per the OASAS LOCADTR 3.0 Manual, (Adult and Adolescent ) Opioid Treatment Programs (OTP). Opioid Treatment Programs (16+ only) are defined as OASAS-certified sites where methadone or other approved medications are administered to treat opioid dependency following one or more medical treatment protocols as defined by 14 NYCRR Part 822. OTPs offer medical and support services including counseling, educational, and vocational rehabilitation. OTP also includes the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 13. A physician serves as medical director and physician and nursing staff assess each individual and approve the plan of care. Clinical staff provide individual, family and group counseling. Patients are prescribed and delivered medication assisted treatment, which is expected to be long-term medication management of a chronic disorder. Many patients are provided treatment over a lifetime similar to chronic management of diabetes or a heart condition.

For Commercial, Medicaid, FIDA and Dually Eligible members, when treatment is provided within New York State, please refer to the OASAS Outpatient Clinic and Opioid Treatment Programs LOCADTR Criteria. When treatment is provided outside of New York State and for all other lines of business, see ASAM Level 1, Outpatient Services.

**B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)** - This is a short term service for members who require additional support to:

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

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

**Home Based Therapy-Plus (HBTP)**
HBTP is appropriate for members who meet the following criteria:

- History of treatment non- which has resulted in poor functionality in the community
  1. HBPT is available for members who History of 2 or more admissions in less than 12 months
2. Presence of co-occurring medical and BH disorders
3. First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression
<table>
<thead>
<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All of the following criteria 1 - 5 must be met; and at least one of criteria 6 – 7 must also be met:</strong></td>
<td><strong>All of the following criteria 1 - 6 must be met:</strong></td>
<td><strong>Any one of the following: Criteria 1, 2, 3 or 4; Criteria 5 – 6 are recommended, but optional:</strong></td>
</tr>
<tr>
<td>1) Member must have a DSM or corresponding ICD diagnosis of a psychiatric disorder.</td>
<td>1) Member continues to meet admission criteria and another less intensive LOC is not appropriate.</td>
<td>1) Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive.</td>
</tr>
<tr>
<td>2) Member can be maintained adequately and safely in their home environment.</td>
<td>2) Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC.</td>
<td>2) Member or parent/guardian withdraws consent for treatment.</td>
</tr>
<tr>
<td>3) Member has the capacity to engage and benefit in treatment.</td>
<td>3) Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals.</td>
<td>3) Member and/or parent/caregiver do not appear to be participating in the treatment plan.</td>
</tr>
<tr>
<td>4) Member agrees to participate in psychiatric home based treatment.</td>
<td>4) Member appears to be benefiting from the service.</td>
<td>4) Member is not making progress toward goals, nor is there expectation of any progress.</td>
</tr>
<tr>
<td>5) Member’s level of functioning in areas such as self-care, work, family living, and social relations is impaired.</td>
<td>5) Member is compliant with treatment plan and continues to be motivated for services.</td>
<td>5) Member’s individual treatment plan and goals have been met.</td>
</tr>
<tr>
<td>6) Member has social/emotional barriers that cannot be adequately managed in an office-based program setting.</td>
<td>6) Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC</td>
<td>6) Member’s support system is in agreement with the aftercare treatment plan.</td>
</tr>
<tr>
<td>7) Member has history of non-compliance in terms of routine office based services, which has recently resulted in placement in a more intensive LOC.</td>
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<tr>
<td><strong>For HBTP, at least one from Criteria 8 through 11 must also be met:</strong></td>
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<tr>
<td>8) History of 2 or more admissions in less than 12 months</td>
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<tr>
<td>9) Presence of co-occurring medical and BH disorders.</td>
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<tr>
<td>10) First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression)</td>
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<tr>
<td>11) History of treatment non- which has resulted in poor functionality in the community</td>
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</table>
C. NMNC 6.604.04 Applied Behavioral Analysis (Adolescent/Child)

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

<table>
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<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
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<tbody>
<tr>
<td><strong>All of the following criteria must be met:</strong></td>
<td><strong>All of the following criteria must be met:</strong></td>
<td><strong>Any one of the following criteria must be met:</strong></td>
</tr>
<tr>
<td>1) The member has behavioral symptoms consistent with a DSM or corresponding ICD diagnosis for Autism Spectrum Disorders or other diagnosis as required by state or federal law;</td>
<td>1) Member continues to meet admission criteria;</td>
<td>1) Member no longer meets admission criteria and/or meets criteria for another level of care; or</td>
</tr>
<tr>
<td>2) The diagnosis is determined by a qualified provider such as a developmental pediatrician, pediatric neurologist, psychiatrist or independently licensed and credentialed psychologist, or as permitted by state or federal law;</td>
<td>2) There is no other level of care that would more appropriately address member’s needs;</td>
<td>2) Member’s individual treatment plan and goals have been met; or</td>
</tr>
<tr>
<td>3) Member has specific challenging behavior(s) and/or level of functional deficits attributable to the autism spectrum disorder (e.g. self-injurious, stereotypic/repetitive behaviors, aggression toward others, elopement, severely disruptive behaviors) that result(s) in significant impairment in one or more of the following:</td>
<td>3) Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated in a less restrictive level of care;</td>
<td>3) Parent/guardian/caregiver is capable of continuing the behavioral interventions; or</td>
</tr>
<tr>
<td>a) personal care; or</td>
<td>4) Treatment/intervention plan includes age appropriate, clearly defined behavioral interventions with measurable goals to target problematic behaviors;</td>
<td>4) Parent/guardian withholds consent for treatment</td>
</tr>
<tr>
<td>b) psychological function; or</td>
<td>5) Member’s progress is monitored as regularly evidenced by behavioral graphs, progress notes, and daily</td>
<td>5) Member is not making progress toward goals, nor is there any expectation of progress</td>
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<tr>
<td>c) vocational functioning; or</td>
<td></td>
<td>6) Member’s support system is in agreement with the</td>
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<td>d) educational performance; or</td>
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</table>
f) communication disorders

4) For outpatient ABA, the member can be adequately and safely maintained in his/her home environment and does not require a more intensive level of care due to imminent risk to harm to self or others or severity of maladaptive behaviors.

5) member’s challenging behavior(s) and/or level of functioning is expected to improve with intensive ABA.

6) The member is not currently receiving any other in home or office-based Intensive behavioral Service (IBI) or ABA services.

7) As appropriate, parents and/or primary caretakers are included in treatment-planning and a skill-development process.

**Exclusions**

Any one of the following criteria are sufficient for exclusion from this level of care:

1) Member has medical conditions or impairments that would prevent beneficial utilization of services.

2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting.

3) The following services are not included within the ABA treatment process and will not be certified:
   a) Speech therapy (may be covered separately under health benefit)
   b) Occupational therapy (may be covered separately under health benefit)
   c) Physical Therapy
   d) Vocational rehabilitation (may be covered separately under health benefit)
   e) Supportive respite care
   f) Recreational therapy
   g) Orientation and mobility

- session notes. if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives; the treatment plan should be modified

6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out;

7) There is a documented active attempt at coordination of care with parent(s) / guardian(s), relevant providers, etc., when appropriate. If coordination is not successful, the reasons are documented;

8) Coordination of care and discharge planning are ongoing with the goal of transitioning member to a less intensive behavioral intervention and a less intensive level of care;

transition / discharge treatment plan;
| h) Respite care |
| i) Equine therapy/Hippo therapy |
| j) Dolphin therapy |
| k) ABA treatment for diagnoses other than Autism Spectrum Disorder, unless otherwise mandated by state/federal law, or elected by contractual obligation |

4) Other educational services

Reference Sources
Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)

2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines

3) National health institutes: National Institutes of Health (NIH); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institutes of Drug Abuse (NIDA); Substance Abuse and Mental Health Services Administration (SAMHSA)

4) Professional publications and psychiatric texts: [see Beacon’s Publication Reference Table]

5) Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)

6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)

D. Developmental Screening (Article 28 and 31 Clinics only)
Developmental screening provides parents and professionals with information on whether a child's development is similar to other children of the same age.

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

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

To read The American Academy of Pediatrics definition of developmental screening, click here (http://www.aap.org/healthtopics/early.cfm). The AAP now recommends developmental screening of all children at ages 9-, 18-, and 30-months. Targeted screening happens when screening is conducted because of concerns about a child.
Article 28 and 31 clinics will be reimbursed for up to 4 units (hours) of developmental screening without prior authorization. For additional units, providers may request the Developmental Screening Supplemental Form.

E. NMNC 5.502.04 Psychological and Neuropsychological Testing (Adult/Adolescent/Child)

Psychological and neuropsychological testing is the use of standardized assessment tools to gather information relevant to a member’s intellectual, cognitive, and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall psychological and neuropsychological functioning. Testing results should inform subsequent treatment planning. A licensed psychologist performs psychological testing, either in independent practice as a health services provider, or in a clinical setting. Psychology doctoral candidates may test members and interpret test results; provided the evaluation is conducted in a clinical setting, and that the testing is directly supervised and co-signed by a qualified licensed psychologist. Psychology assistants may not test members under the supervision of a psychologist in an independent practice setting. Neuropsychological testing is most often utilized for members with cognitive impairments that impede functioning on a day to day basis.

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

- Testing is approved only for licensed psychologists and other clinicians for whom testing falls within the scope of their clinical license and have specialized training in psychological and/or neuropsychological testing.

- Educational testing is not a covered benefit, though this may be subject to state and account-specific arrangements. Assessment of possible learning disorder or developmental disorders is provided by school system per federal mandate PL 94-142.

- When neuropsychological testing is requested secondary to a clear, documented neurological injury or other medical/neurological condition (i.e. Stroke, traumatic brain injury multiple sclerosis), this may be referred to the medical health plan, though this determination may be subject to state and account-specific guidelines. A Neurology consult may be required prior to issuing the request.

- All tasks involving projective testing must be performed by a licensed psychologist or other licensed clinician, qualified via specialized training in projective testing and practicing under the scope of their licensure. A psychiatric consult is sufficient for most ADHD diagnostic determinations and psychological testing is typically not required.

- Testing requested by the legal or school system is not generally a covered benefit, unless specified by state regulations or account-specific arrangements.
<table>
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<tr>
<th>Admission Criteria</th>
<th>Criteria for Tests</th>
<th>Non-Reimbursable Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following criteria must apply:</td>
<td>Both of following criteria must be met:</td>
<td>Only one of the following criteria must be met for a test to be non-reimbursable.</td>
</tr>
<tr>
<td>For Psychological Testing, all criteria 1 – 6 must be met; for Neuropsychological Testing, #7 must also be met</td>
<td>1) Tests must be published, valid, and in general use as evidenced by their presence in the current edition of <em>Tests in Print</em> IX, or by their conformity to the <em>Standards for Educational and Psychological Tests</em> of the American Psychological Association.; and 2) Tests are administered individually and are tailored to the specific diagnostic questions of concern.</td>
<td>1) Self-rating forms and other paper and pencil instruments, unless administered as part of a comprehensive battery of tests, (e.g., <em>MMPI</em> or <em>PIC</em>) as a general rule; or 2) Group forms of intelligence tests; or 3) Short form, abbreviated, or “quick” intelligence tests administered at the same time as the <em>Wechsler</em> or <em>Stanford-Binet</em> tests; or 4) A repetition of any psychological test or tests provided to the same individual within the preceding six months, unless documented that the purpose of the repeated testing is to ascertain changes: including one of the following factors: a) Following such special forms of treatment or intervention such as ECT; or b) Relating to suicidal, homicidal, toxic, traumatic, or neurological conditions; or c) As specified in Admission Criteria 1c</td>
</tr>
<tr>
<td>1) Request for testing is based on need for at least one of the following: a. Differential diagnosis of mental health condition unable to be completed by traditional assessment; or b. Diagnostic clarification due to a recent change in mental status for appropriate level of care determination / treatment needs due to lack of standard treatment response; or c. if testing request is a repeat of prior psychological testing, clinical situation must represent one of the following: • clinically significant change in member's status (i.e., worsening or new symptoms or findings); or • other need for interval reassessment that will inform treatment plan</td>
<td></td>
<td>5) Tests for adults that fall in the educational arena or in the domain of learning disabilities; or 6) Testing that is mandated by the courts, Department of Children's Services or other social/legal agency</td>
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<tr>
<td>2) Results of proposed testing are likely to inform care or treatment of member (i.e., contribute substantially to modification of a rehabilitation or treatment plan)</td>
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<tr>
<td>3) Results expected to help answer question that medical, neurologic, or psychiatric evaluation, diagnostic testing, observation in therapy, or other assessment cannot</td>
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<tr>
<td>4) Member is able to participate as needed such that proposed testing is likely to be feasible (i.e., appropriate mental status, intellectual abilities, language skills)</td>
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<tr>
<td>5) No active use, withdrawal, or in process of recovery from chronic substance use</td>
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<td>6) Diagnostic evaluations completed (e.g., CT scan, MRI), including psychosocial functioning), unless subject to state regulation or account-specific arrangements</td>
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LEVEL OF CARE CRITERIA- NEW YORK

CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19

35
7) The member is experiencing cognitive or behavioral impairments, and the member’s condition presents a significant cognitive deficit, mental status abnormality, behavioral change, or memory loss that requires quantification, monitoring of change, or differentiation of cause (e.g., organic cognitive vs psychiatric disease).

Exclusions

Any one of the following criteria are sufficient for exclusion from this level of care:

1) Testing is primarily to guide the titration of medication; or
2) Testing is primarily for legal purposes, unless specified by state regulations or account-specific arrangements; or
3) Testing is primarily for medical guidance, cognitive rehabilitation, or vocational guidance, as opposed to the admission criteria purposes stated above.
4) Testing request appears more routine than medically necessary (i.e. a standard test battery administered to all new members); or
5) Interpretation and supervision of neuropsychological testing (excluding the administration of tests) is performed by someone other than a licensed psychologist or other clinician whom neuropsychological testing falls within the scope of their clinical license, and who has had special training in neuropsychological testing; or
6) Measures proposed have no standardized norms or documented validity; or
7) The time requested for a test/test battery falls outside Beacon Health Options established time parameters; or
8) Extended testing for ADHD has been requested prior to provision of a thorough evaluation, which has included a developmental history of symptoms and administration of rating scales; or

in the absence of a clear clinical rationale; or
7) Periodic testing solely to measure the member’s response to psychotherapy
9) Administration, scoring and/or reporting of projective testing is performed by someone other than a licensed psychologist, or other clinician for whom psychological testing falls within the scope of his/her clinical licensure and who has specialized training in psychological testing.

Reference Sources
Beacon's Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
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5) Federal/state regulatory and industry accreditation requirements, including CMS's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)

F. NMNC 5.503.02 Biofeedback (Adult/Adolescent/Child)

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

Although all treatment approval is subject to the general admission and exclusion criteria delineated below, the following are guidelines regarding the most common issues:

- Biofeedback has been used to treat children and adults with a wide variety of medical and behavioral health issues. Biofeedback is used for medical conditions including but not limited to fecal incontinence, irritable bowel syndrome, chronic constipation, migraines, and adjunctive treatment for Raynaud’s disease, tension headaches, pain and neuromuscular rehabilitation after a stroke or traumatic brain injury. Behavioral health conditions may include ADHD, Anxiety and Autism.
• Treatment of medical conditions may or may not be covered under the member’s physical health coverage. Requests for these disorders should be directed to the medical carrier. Coverage may be determined under the medical/behavioral mixed services protocol defining coverage responsibility.
• Biofeedback is typically performed in the outpatient office setting. It is not typically provided as a stand-alone treatment, but used adjunctively to other therapies, including psychotherapy and medication.
• There is no current required separate certification in biofeedback. However, there are certification entities (i.e., Biofeedback Certification International Alliance).
• Biofeedback may or may not be a covered health plan benefit. When biofeedback is requested to treat a behavioral health condition and not covered, an administrative determination of non-coverage will be rendered. The current determination by Beacon Health Options Scientific Review Committee is that biofeedback does not currently meet the criteria standard for inclusion as an evidence-based treatment for behavioral health disorders. Although not conclusive, the treatment of anxiety disorders has the most supporting evidence for the use of biofeedback.
• Application of the following criteria is contingent on biofeedback being a covered benefit/non-excluded from a state or client-specific contract.
• If Biofeedback is specifically included as a covered benefit and the request is for the treatment of an Anxiety Disorder, these criteria are to be used.
• If Biofeedback is specifically included as a covered benefit and the request is for any other diagnosis than an Anxiety Disorder, the specific diagnosis must be included under the Biofeedback coverage document for these medical necessity criteria to be used. If the particular diagnosis is not specifically covered, an administrative determination of non-coverage should be rendered (unproven for that diagnosis).

<table>
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<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
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</thead>
<tbody>
<tr>
<td>Either 1 or 2 of the following criteria must be met:</td>
<td>All of the following criteria must be met:</td>
<td>Any one of the following criteria must be met for discharge from this level of care</td>
</tr>
<tr>
<td>1) Biofeedback is a listed covered benefit with no specific included diagnoses and is being requested for the treatment of an Anxiety Disorder listed in the most current version of the (DSM) and can be reasonably expected to respond to this treatment modality as a component of a comprehensive treatment plan; or</td>
<td>1) Member continues to meet admission criteria for Biofeedback.</td>
<td>1) Members documented treatment plan goals and objectives have been substantially met; or</td>
</tr>
<tr>
<td>2) Biofeedback is a covered benefit with specific included diagnoses and the request for services is for a covered diagnosis listed in the most recent</td>
<td>2) Member does not require a more intensive level of care or service, and no less intensive services are appropriate.</td>
<td>2) Member no longer meets admission criteria, or meets criteria for a</td>
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</table>
All of the following criteria must be met: | 3) The frequency of sessions is occurring or scheduled to occur at a rate that is appropriate to the members current symptoms, and no less frequency of | |
Exclusions

Any one of the following criteria are sufficient for exclusion from this level of care:

1) Biofeedback is being requested for a physical health condition (request should be directed to medical plan); or
2) Member has conditions or impairments that would prevent beneficial utilization of Biofeedback; or
3) Biofeedback is being requested for any behavioral health diagnosis except one specifically listed as covered under the benefit plan or is an Anxiety Disorder in the absence of specifically covered diagnoses listed in the most recent version of the DSM; or
4) Biofeedback is not being used as an adjunctive treatment in a comprehensive treatment regimen.
5) Standard accepted outpatient treatments (including psychotherapy and medication management) are sufficient to safely and effectively treat the individual.

sessions would be sufficient to meet this/her needs.
4) Treatment planning is individualized and appropriate to the members changing condition with realistic and specific goals and objectives stated.
5) All services and treatment are carefully structured to achieve optimum results in the most efficient manner possible, consistent with sound clinical practice. Expected benefit from the Biofeedback is documented.
6) Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident. or Continued Biofeedback is expected to prevent the need for more intensive services or levels of care.
7) Care is rendered in a clinically appropriate manner and focused on the members behavioral and functional outcomes as described in the discharge plan.
8) When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner.
9) There is documented active discharge planning from the beginning of treatment, which includes ensuring the ability of the member to continue the

3) Member is competent and non-participatory in treatment, or the members non-participation is of such degree that treatment is rendered ineffective, or unsafe despite multiple, documented attempts to address non-participation issues; or
4) Consent for treatment is withdrawn and it is determined that the member has the capacity to make an informed decision; or
5) Member is not making progress toward treatment goals, and there is no reasonable expectation of progress with this treatment approach; or
6) It is reasonably predicted that continuing stabilization can occur with discontinuing Biofeedback with ongoing medication management and/or psychotherapy and
Biofeedback learned techniques independently after discharge.

community support.

Reference Sources
Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA); American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA); American Academy of Child and Adolescent Psychiatry (AACAP)
2) National care guideline and criteria entities: American Society of Addiction Medicine (ASAM); MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH), National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Drug Abuse (NIDA), Substance Abuse and Mental Health Services Administration (SAMHSA)
4) Professional publications and psychiatric texts: [see Beacon’s Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)

SECTION V: OTHER SPECIAL BEHAVIORAL HEALTH SERVICES

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

A. NMNC 6.601.04 Electro-Convulsive Therapy (Adult/Adolescent/Child)
B. Personalized Recovery Orientated Services (PROS) (Minimum age is 18)
C. Assertive Community Treatment (ACT) (Minimum age is 18)
D. NMNC 6.602.04 Transcranial Magnetic Stimulation
E. Home and Community Based Services (Use of this level of care is specific to a Health Plan’s authorization requirements) (Adult)
F. Home and Community Based Services (Children)
G. Children’s Family Treatment and Support Services (CFTSS)
A. NMNC 6.601.04 Electro-Convulsive Therapy (Adult/Adolescent/Child)

Electro-Convulsive (ECT) Therapy is a procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity while the member is under general anesthesia. This procedure can be administered in a variety of settings, ranging from a licensed hospital to outpatient settings. The decision to pursue ECT treatments is based on a risk/benefit analysis based on the member’s history, medical issues, symptomatology, and anticipated adverse side effects. Providers must complete a work-up including medical history, physical examination, and any indicated pre-anesthetic lab work to determine whether there are contraindications to ECT-related anesthesia and that there are no less intrusive alternatives before scheduling administration of ECT. The member must, as required by state or federal specific requirements, provide separate written informed consent to ECT on forms provided by the specific state mental health agency, as consent to other forms of psychiatric treatment are considered separate. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments. In general, an acute course of ECT will consist of 3 sessions per week for a total of 6 to 12 sessions. For members who achieve remission with ECT but are not able to maintain remission with pharmacotherapy, ECT may be administered as a maintenance treatment and is provided at a reduced frequency (e.g., weekly, biweekly, monthly). Maintenance ECT may be indicated for long-term maintenance when there is evidence that discontinuation or reduction in frequency is likely to result in a relapse.

<table>
<thead>
<tr>
<th>Admission Criteria</th>
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<th>Discharge Criteria</th>
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<tbody>
<tr>
<td>All of the following criteria must be met:</td>
<td>All of the following criteria must be met:</td>
<td>Any one or more of the following criteria must be met:</td>
</tr>
<tr>
<td>1) DSM or corresponding ICD diagnosis of major depression, schizophrenia, schizoaffective disorder, or other disorder with features that include mania, psychosis, and/or catatonia;</td>
<td>1) The member continues to meet admission criteria;</td>
<td>1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; or</td>
</tr>
<tr>
<td>2) Member has been medically cleared and there are no contraindications to ECT (i.e. Intracranial, cardiovascular, or pulmonary contraindications)</td>
<td>2) An alternative treatment would not be more appropriate to address the members ongoing symptoms;</td>
<td>2) Member withdraws consent for treatment or refuses treatment and does not meet criteria for involuntary mandated treatment; or</td>
</tr>
<tr>
<td>3) There is an immediate need for rapid, definitive response due to at least one of the following:</td>
<td>3) The member is in agreement to continue treatment of ECT</td>
<td>3) Member is not making progress toward goals,</td>
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<tr>
<td>a) significant risk of harm to self or others; or</td>
<td>4) Treatment is still necessary to reduce symptoms and improve functioning</td>
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<td>b) catatonia; or</td>
<td>5) There is evidence of subjective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress</td>
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<tr>
<td>c) intractable manic episode; or</td>
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<td>d) other treatments could potentially harm the member due to slower onset of action.</td>
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LEVEL OF CARE CRITERIA- NEW YORK
CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19
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4) The benefits of ECT outweigh the risks of other treatments as evidenced by **at least one** of the following:
   a) member has not responded to adequate medication trials; or
   b) member has had a history of positive response to ECT.
5) Maintenance ECT, as indicated by **all** of the following:
   a) Without maintenance ECT member is at risk of relapse
   b) Adjunct therapy to pharmacotherapy
   c) Sessions tapered to lowest frequency that maintains baseline

**Exclusions**

**Any one of the following criteria are sufficient for exclusion from this level of care:**

1) The individual can be safely maintained and effectively treated with a less intrusive therapy; or
2) Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific individual from this level of care. Such conditions include but are not limited to:
   a) unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease;
   b) aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure;
   c) increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions;

6) The total number of treatments administered is proportional to the severity of symptoms, rate of clinical improvement, and adverse side effects
7) There is documented coordination with family and community supports as clinically appropriate
8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.

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LEVEL OF CARE CRITERIA- NEW YORK  CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19
Reference sources
Beacon’s Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence-based guidelines derived from:
1) Professional societies: American Psychiatric Association (APA)
2) National care guideline and criteria entities: MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH)
4) Professional publications and psychiatric texts: [Beacon’s Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)

B. Personalized Recovery Orientated Services (PROS) (Minimum age is 18)

PROS programs offer a customized array of recovery-oriented services, both in traditional program settings and in off-site locations where people live, learn, work or socialize. The purpose of PROS is to assist individuals in recovering from the disabling effects of mental illness through the coordinated delivery of rehabilitation, treatment and support services. Goals for members in the program may include, but are not limited to improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing. There are four service components, including Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and clinical treatment.

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

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<tr>
<th>Admission Criteria</th>
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<th>Discharge Criteria</th>
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</table>

- d) recent cerebral infarction;
- e) pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia;
- f) anesthetic risk rated as American Society of Anesthesiologists level 4 or 5.

LEVEL OF CARE CRITERIA- NEW YORK

CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19

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### All of the following criteria 1 – 10 must be met:

1. The member has a designated mental illness diagnosis.
2. The member must be 18 years of age or older.
3. The member must be recommended for admission by a Licensed Practitioner of the Healing Arts.
4. The member exhibits functional deficits related to the severity and duration of a psychiatric illness in any of the following areas: self-care, activities of daily living, interpersonal relations, and/or adaptation to change or task performance in work or work-like settings.
5. Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP.
6. Admission begins when ISR is approved by MMCO/HARP. IRP must be developed within 60 days of admission date.
7. Active Rehabilitation begins when the Individualized Recovery Plan ("IRP") is approved by the MMCO/HARP and IRP indicates required services designed to engage and assist members in managing their illness and restoring those skills and supports necessary for living successful in the community.
8. The individual has developed or is interested in developing a recovery/life role goal.
9. There is not a lower level of care which is more appropriate to assist member with recovery goals.
10. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

### All of the following criteria 1 – 3 must be met:

1. The member continues to work towards goals, identified in an IRP.
2. Concurrent review and authorizations should occur at 3-month intervals for IR, ORS, and 6 month intervals for CRS and Clinic Treatment services. Continuing stay criteria may include:
   a) The member has an active recovery goal and shows progress toward achieving it; OR
   b) The member has met and is sustaining a recovery goal, but, would like to pursue a new goal; OR
   c) The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate; OR without PROS services the individual would require a higher level of care.
3. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

### Any one of the following: Criteria 1, 2, 3, or 4:

1. The member has sustained recovery goals for 6-12 months and a lower level of care is clinically indicated.
2. The member has achieved current recovery goals and can identify no other goals that would require additional PROS services.
3. The member is not participating in a recovery plan and is not making progress toward any goals. Extensive engagement efforts have been exhausted, and there is insignificant expected benefit from continued participation.
4. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.
## Ongoing Rehabilitation and Support (ORS) Criteria

<table>
<thead>
<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
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</thead>
<tbody>
<tr>
<td>Any one of the following: Criteria 1, 2, 3, or 4:</td>
<td>Any one of the following: Criteria 1, 2, 3, or 4:</td>
<td>Any one of the following: Criteria 1, 2, or 3:</td>
</tr>
<tr>
<td>1) Member has a specific goal related to competitive employment.</td>
<td>1) Member continues to have a goal for competitive employment.</td>
<td>1) The member no longer requires supportive services for managing symptoms in the competitive workplace.</td>
</tr>
<tr>
<td>2) Member should be competitively employed and regularly scheduled for at least 10 hours of work per week, with exceptions made for illness and vacation.</td>
<td>2) Member should be competitively employed and regularly scheduled for at least 10 hours of work per week, with exceptions made for illness and vacation.</td>
<td>2) The member no longer is seeking competitive employment.</td>
</tr>
<tr>
<td>3) Member would benefit from support in managing their symptoms in a competitive workplace.</td>
<td>3) Member continues to benefit from supportive services in managing their symptoms in the competitive workplace.</td>
<td>3) The member has achieved current recovery goals and can identify no other goals that would require ongoing rehabilitation and support.</td>
</tr>
<tr>
<td>4) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.</td>
<td>4) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.</td>
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</table>
### Intensive Rehabilitation (IR) Criteria

<table>
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<tr>
<th>Admission Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
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<tbody>
<tr>
<td><strong>Any one of the following: Criteria 1, 2, 3, 4, or 5:</strong></td>
<td><strong>Any one of the following: Criteria 1, 2, 3, 4, or 5:</strong></td>
<td><strong>Any one of the following: Criteria 1, 2, or 3:</strong></td>
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<tr>
<td>1) Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe.</td>
<td>1) Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe.</td>
<td>1) The member is no longer at risk of hospitalization, involvement in criminal justice system and community tenure is assured in which intensive rehabilitation is no longer required.</td>
</tr>
<tr>
<td>2) The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention.</td>
<td>2) The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention.</td>
<td>2) The member has achieved current recovery goals and can identify no other goals that would require intensive rehabilitation.</td>
</tr>
<tr>
<td>3) Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure.</td>
<td>3) Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure.</td>
<td>3) The member can live, learn, work and socialize in the community with supports from natural and/or community resources without intensive rehabilitation.</td>
</tr>
<tr>
<td>4) Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Treatment for Dual Disorders.</td>
<td>4) Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Treatment for Dual Disorders.</td>
<td></td>
</tr>
<tr>
<td>5) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.</td>
<td>5) A member is not receiving Home and Community Services other than peer support services,</td>
<td></td>
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</table>
C. Assertive Community Treatment (ACT) (Minimum age is 18)

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

<table>
<thead>
<tr>
<th>Initial Authorization Criteria</th>
<th>Continued Stay Criteria</th>
<th>Discharge Criteria</th>
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<tbody>
<tr>
<td>All of the following criteria 1 - 5 must be met; Criteria 6 &amp; 7 may also be met:</td>
<td>1) Initial authorization criteria continue to be met. &lt;br&gt;2) A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals. Service plan is reviewed for progress and updated every 6 months, as necessary.</td>
<td>Any one of the following: &lt;br&gt;Criteria 1, 2, 3, or 4; &lt;br&gt;Criteria 5 &amp; 6 are recommended, but optional: &lt;br&gt;ACT recipients meeting any of the following criteria may be discharged: &lt;br&gt;1) Individuals who demonstrate, over a period of time, an ability to function</td>
</tr>
<tr>
<td>1) Severe and persistent mental illness (including, but, not limited to diagnoses of schizophrenia, schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression), that seriously impairs their functioning in the community.</td>
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<tr>
<td>2) Recipients with serious functional impairments should demonstrate at least one of the following conditions:</td>
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education support services and crisis residential services.
| a) Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives. |
| b) Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role. |
| c) Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing). |

3) Recipients with continuous high service needs should demonstrate one or more of the following conditions:
   a) Inability to participate or succeed in traditional, office-based services or case management.
   b) High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
   c) High use of psychiatric emergency or crisis services.
   d) Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).
   e) Co-existing substance abuse disorder (duration greater than 6 months).
   f) Current high risk or recent history of criminal justice involvement.
   g) Court ordered pursuant to participate in Assisted Outpatient Treatment.
   h) Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.
   i) Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.
   j) Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.

4) Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision.

3) Continued coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc.

4) Active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC, when appropriate.

4) Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail.

5) Individuals who request discharge, despite the team’s best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a
5) Member’s condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions.
6) Member is stepping down from a higher level of care (LOC) and requires more intensive services than routine outpatient behavioral health treatment or other community based supports; and/or has past history of a similar clinical presentation where less intensive treatment was not sufficient to prevent clinical deterioration and the need for a higher LOC.
7) For children or adolescents, the parent or guardian agrees to participate in the member's treatment plan, as appropriate. Priority is given to individuals with SMI, individuals with continuous high service needs that are not being met in more traditional service settings, and individuals with ACT in their AOT order.

Exclusions

The following criteria is required for exclusion from this level of care:

1) Individuals with a primary diagnosis of a substance abuse disorder or mental retardation and members with a sole diagnosis of a personality disorder are not appropriate for ACT. The member is not enrolled in HCBS services other than crisis residential services.

D. NMNC 6.602.04 Transcranial Magnetic Stimulation

Description of Services: Transcranial Magnetic Stimulation (TMS) is a noninvasive method of brain stimulation. In TMS, an electromagnetic coil is positioned against the individual’s scalp near his or her forehead. A Magnetic Resonance Imaging (MRI)-strength, pulsed, magnetic fields then induce an electric current in a localized region of the cerebral cortex, which induces a focal current in the brain and temporary modulation of cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Depending on stimulation parameters, TMS to specific cortical regions can either decrease or increase the excitability of the targeted structures. TMS does not induce seizures or involve complete sedation with anesthesia in contrast to ECT. The FDA approval for this treatment modality was sought for patients with treatment resistant depression. Additionally, the population for which efficacy has been in the literature is that with treatment resistant depression. Generally speaking, in accordance with the literature, individuals would be considered to have treatment resistant depression if their current episode of depression was not responsive to two trials of medication in different classes for adequate duration dose, and with treatment adherence. TMS is usually administered four to six times per week and for six weeks or less. It is typically performed in an outpatient office. TMS is
not considered proven for maintenance treatment. The decision to recommend the use of TMS derives from a risk/benefit analysis for the specific member. This analysis considers the diagnosis of the member and the severity of the presenting illness, the member’s treatment history, any potential risks, anticipated adverse side effects and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

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<td><strong>All of the following criteria must be met:</strong></td>
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<td><strong>Any one of the following criteria must be met:</strong></td>
</tr>
<tr>
<td>1) The member must be at least 18 years of age.</td>
<td>1) The member continues to meet admission criteria</td>
<td>1) The member has achieved adequate stabilization of the depressive symptoms; or</td>
</tr>
<tr>
<td>2) The individual demonstrates behavioral symptoms consistent with Major Depression Disorder (MDD), severe degree without psychotic features, either single episode, or recurrent, as described in the most current version of the DSM, or corresponding ICD, and must carry this diagnosis.</td>
<td>2) An alternative treatment would not be more appropriate to address the members ongoing symptoms</td>
<td>2) Member withdraws consent for treatment; or</td>
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<tr>
<td>3) Depression is severe as defined and documented by a validated, self-administered, evidence-based monitoring tool [i.e., Patient Health Questionnaire -9 (PHQ-9), Beck Depression Inventory (BDI), Hamilton Depression Rating Scale (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS), Inventory for Depressive Symptomatology Systems Review (IDS-SR), etc.].</td>
<td>3) The member is in agreement to continue TMS treatment and has been adherent with treatment plan</td>
<td>3) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; or</td>
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<tr>
<td>4) The diagnosis of MDD cannot be made in the context of current or past history of manic, mixed or hypomanic episode.</td>
<td>4) Treatment is still necessary to reduce symptoms and improve functioning</td>
<td>4) Member is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement (e.g. validated rating scale and behavioral description) and there is no reasonable expectation of progress; or</td>
</tr>
<tr>
<td>5) The member has no active (within the past year) substance use or eating disorders.</td>
<td>5) There is evidence of objective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress</td>
<td>5) Worsening of depressive symptoms such as increased suicidal thoughts/behaviors or unusual behaviors.</td>
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<tr>
<td>6) Member must exhibit treatment-resistant depression in the current treatment episode with all of the following:</td>
<td>6) Treatment is to continue within the authorization period only when continued significant clinical benefit is achieved (evidenced by scales referenced throughout this document) and treatment outweighs any adverse effects</td>
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<td>a) Lack of clinically significant response (less than 50% of depressive symptoms)</td>
<td>7) There is documented coordination with family and community supports as appropriate</td>
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<tr>
<td>b) Documented symptoms on a valid, evidence-based monitoring tool; and</td>
<td>8) Medication assessment has been completed when appropriate and</td>
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<td>c) Medication adherence and lack of response to at least</td>
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two psychopharmacologic trials in the current episode of treatment at the minimum dose and from two different medication classes;

7) Member must not meet any of the exclusionary criteria below;

8) TMS is administered by a US Food and Drug Administration (FDA) cleared device for the treatment of MDD in a safe and effective manner according to the manufacturer's user manual and specified stimulation parameters.

9) The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering TMS therapy and directly supervises the procedure (on site and immediately available).

The following criteria may apply:

History of response to TMS in a previous depressive episode as evidenced by a greater than 50% response in standard rating scale for depression (e.g., PHQ-9, BDI, HAM-D, MADRS, QIDS, or the IDS-SR) and now has a relapse after remission and meets all other authorization criteria.

Exclusions

Any one of the following criteria are sufficient for exclusion from this level of care:

1) Member has medical conditions or impairments that would prevent beneficial utilization of services; or

2) Member requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting; or

3) The safety and effectiveness of TMS has not been established in the following member populations or medication trials have been initiated or ruled out.
clinical conditions through a controlled clinical trial, therefore the following are exclusion criteria.

a. Members who have a suicide plan or have recently attempted suicide
b. Members who do not meet current DSM or corresponding ICD criteria for major depressive disorder
c. Members younger than 18 years of age or older than 70 years of age
d. Members with recent history or active substance abuse, obsessive compulsive disorder or post-traumatic stress disorder
e. Members with a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features
f. Members with neurological conditions that include epilepsy, cerebrovascular disease, neurocognitive disorder (dementia), Parkinson’s disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS
g. The presence of vagus nerve stimulator leads in the carotid sheath
h. The presence of a metal or conductive device in the head or body that is contraindicated with TMS. For example, metals that are within 30cm of the magnetic coil and include, but are not limited to, cochlear implants, metal aneurysm coil or clips, bullet fragments, pacemakers, ocular implants, facial tattoos with metallic ink, implanted cardioverter defibrillator, metal plates, vagus nerve stimulator, deep brain stimulation devices and stents
i. Members with nerve stimulators or implants controlled by physiologic signals

**TMS is not indicated for maintenance treatment.**
There is insufficient evidence to support the efficacy of maintenance therapy with TMS. TMS for
maintenance treatment of major depressive disorder is experimental / investigational due to the lack of demonstrated efficacy in the published peer reviewed literature.

Reference sources
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2. National care guideline and criteria entities: MCG Care Guidelines
3. National health institutes: National Institutes of Health (NIH)
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5. Federal/state regulatory and industry accreditation requirements, including CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6. National industry peer organizations including managed care organizations (MCOs) and behavioral health organizations (BHOs)

E. Home and Community Based Services – (Adult)

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in a Health and Recovery Plan (HARP) to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders. These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is collaboration between all pertinent participants including but not limited to the Health Home care manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member’s chosen goals. These conversations will focus on the member’s needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual’s needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

HCBS eligibility will be determined using a standard needs assessment tool, typically administered by the individual’s Health Home (HH) care manager. Provision of Home and Community Based Services requires a person-centered approach to care planning, service authorizations, and service delivery. MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual (latest version available at:
Criteria for HCBS services are defined by the State of New York.

The following is a description of the various HCBS services:

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

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

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

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

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

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

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

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

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

3) Short-Term Crisis Respite Services –

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Admission Criteria:</th>
<th>Continued Stay Criteria:</th>
<th>Discharge Criteria:</th>
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<tbody>
<tr>
<td><strong>All of the following criteria 1 – 7 must be met:</strong></td>
<td><strong>All of the following criteria 1 – 5 must be met:</strong></td>
<td><strong>Any one of the following: Criteria 1, 2, 3, 4, or 5; criteria #6 is recommended, but optional:</strong></td>
</tr>
<tr>
<td>1) The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool.</td>
<td>1) Member continues to meet admission criteria and an alternative service would not better serve the member.</td>
<td>1) Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive.</td>
</tr>
<tr>
<td>2) Where the member has been deemed eligible to receive services, a Level of Service Determination is made to ensure recommended HCBS are appropriate for meeting the member’s identified goals, and appropriate HCBS provider(s) are identified in a conflict-free manner.</td>
<td>2) Interventions are timely, need based as per the CMHA (Full Assessment), consistent with evidence based/best practice, and provided by a designated HCBS provider.</td>
<td>2) Member or parent/guardian withdraws consent for treatment.</td>
</tr>
<tr>
<td>3) Upon receipt of notification from the HCBS provider(s), up to 3 visits over 14 days is authorized for intake and evaluation.</td>
<td>3) One of the following is present:</td>
<td>3) Member does not appear to be participating.</td>
</tr>
<tr>
<td>4) The BH Prior and/or Continuing Authorization Request Form is submitted by the HCBS provider(s) for Prior Authorization and includes service scope, duration and frequency.</td>
<td>a) Member is making measurable progress towards a set of clearly defined goals; Or</td>
<td>4) Member’s needs have changed and current services are not meeting these needs. Member’s self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge, alternative services are being explored</td>
</tr>
<tr>
<td>5) The service request must support the member’s efforts to manage their condition(s) while</td>
<td>b) There is evidence that the service plan is modified to address the barriers in treatment progression; Or</td>
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LEVEL OF CARE CRITERIA- NEW YORK  
CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19  
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establishing a purposeful life and sense of membership in a broader community.

6) The member must be willing to receive home and community based services.

7) There is no alternative level of care or co-occurring service that would better address the member’s clinical needs.

4) There is care coordination with physical and behavioral health providers, State, and other community agencies.

5) Family/guardian/caregiver is participating in treatment where appropriate.

In addition, determination of progress and modifications to goals/objectives are made by reviewing the BH HCBS Prior and/or Continuing Authorization Request Form and/or with a telephonic review with the provider.

5) Member’s goals have been met.

6) Member’s support system is in agreement with the aftercare service plan.

F. Home and Community Based Services – (Children)

Home and Community Based Services (HCBS) are designed to allow children/youth to participate in a vast array of habilitative service, by granting access to a series of Medicaid funded services. New York (NY) has affirmed its commitment to serving individuals in the least restrictive environment by providing services and supports to children and their families to enable them to remain at home and in the community. HCBS are designed for people who, but for these services, require the level of care provider in a more restrictive environment such as in a long-term care facility or psychiatric inpatient care and for those at risk of elevating to that level of care.

The Medicaid Managed Care transition for individual under the age of 21 includes the alignment of the following NY children’s’ waivers currently accessible under the authority of the 1915 (c) amendment of the Federal Social Security Act: Office of Children and Family Services (OCFS) Bridges to Health [B2H Serious Emotional Disturbance (SED), B2H Development Disabilities (DD), B2H medically fragile (MedF), the Office of Mental Health (OMH) SED Waiver, Office for People with Developmental Disabilities (OPWDD) Care at Home (CAH) waiver and the Department of Health (DOH) operated Care at Home (CAH) I/II Waiver

The Office of Alcoholism and Substance Abuse Services (OASAS), OCFS, OMH, and DOH have worked in collaboration to create a newly aligned service array of HCBS benefits for children meeting specific criteria. The 1115 Medicaid Redesign Team (MRT) Waiver, with approval from the Centers for Medicare and Medicaid Services (CMS), provides NYS the authority for these HCBS benefits. Included in the 1115 are person-centered planning requirements as well as specifics on the transitional coverage requirement for children currently enrolled in 1915(c) waivers at the time of transition.
HCBS eligibility includes 1) target criteria; 2) risk factors and 3) functional criteria as well as Medicaid eligibility. These criteria are currently limited to children that would otherwise qualify for institutional placement Level of Care (LOC) criteria. The 1115 federal authority seeks to expand LOC to include a new needs-based criteria category referred to as Level of Need, allowing more children to access HCBS benefits. This expansion group addresses gaps in service where a child who may benefit from HCBS was not eligible based on higher functioning.

New York State will continue to use the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool to assure person-centered services planning for HCBS eligible children/youth.

MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual (latest version available at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-10-06_draft_hcbs_prov_manual.pdf)

The following is a description of the various HCBS services:

1) **Habilitation**- Habilitation services assists children/youth with developmental, medical or behavioral disabilities with the self-help, socialization, and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate.

2) **Caregiver/Family Supports and Services**- Caregiver/Family Supports and Services enhance the child/youth's ability regardless of disability (developmental, physical and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family’s ability to care for the child/youth in the home and/or community. Family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

   Note: this service is not the State Plan service of Family Peer Support Services, which is delivered by a certified Family Peer with lived experience.

3) **Respite**- This service focuses on short-term assistance and/or relief for children/youth with disabilities (developmental, physical and/or behavioral), and family/caregivers which can be provided in a planned mode or delivered in a crisis environment. Respite workers supervise the child/youth and engage the child in activities that support his/her and or caregiver/family’s constructive interests and abilities. Respite providers will offer services with a level of expertise in understanding and implementing behavioral/developmental interventions required to support optimal functioning for children/youth. Respite providers will regularly communicate the details of the child/youth’s intervention plan so that there is a carryover of skill from the respite source to the caregivers and treatment providers.

   To the extent that skilled nursing is provided as a form of respite, this service has to be ordered by a physician.

4) **Prevocational Services**- Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work or career exploration. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any
work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth’s plan of care and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements. Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant’s interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to:

- ability to communicate effectively with supervisors;
- co-workers and customers;
- generally accepted community workplace conduct and dress;
- ability to follow directions;
- ability to attend to and complete tasks;
- punctuality and attendance;
- appropriate behaviors in and outside the workplace;
- workplace problem solving skills and strategies;
- mobility training; career planning;
- proper use of job-related equipment and general workplace safety

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment. Prevocational services will not be provided to an HCBS participant if:

(i) Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR).
(iii) Vocational services that are provided in facility based work settings that are not integrated settings in the general community workforce.

5) Supported Employment- Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting. Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and
level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Supported employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.

In addition to the need for an appropriate job match that meets the individual’s skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant’s support needs, changes in life situations, or evolving and changing job responsibilities.

Supported Employment service will not be provided to an HCBS participant if:
(i) Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
(ii) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.
(iii) Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
(iv) Supported employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
(v) Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
• Incentive payments made to an employer to encourage or subsidize the employer’s participation in supported employment; or
• Payments that are passed through to users of supported employment services.

6) Community Self-Advocacy Training and Supports- Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical and/or behavioral health in origin).
Success in these activities is dependent not only on the child/youth, but on the people who interact with and support the child/youth in these endeavors. Community Self-Advocacy Training and Support improves the child/youth’s ability to gain from the community experience, and enables the child/youth’s environment to respond appropriately to the child/youth’s disability and/or health care issues.

Community Self-Advocacy Training and Support is intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant’s needs related to their disability(ies).

Community Self-Advocacy Training and Support provides family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth is experiencing difficulty. The Plan of Care objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth.

7) Non-Medical Transportation - Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth’s Plan of Care.

Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive, a job interview, college fair, wellness seminar, a GED preparatory class, etc. This service will be provided to meet the child/youth’s needs as determined by an assessment performed in accordance with the state’s requirements and as outlined in the child/youth’s Plan of Care.
Children’s Utilization Management Guidelines (Criteria defined by the State of New York.)

THE SIX CHILDREN’S FAMILY TREATMENT AND SUPPORT SERVICES (CFTSS)-UPDATED December 2017
Guidelines for Medical Necessity Criteria

Other Licensed Practitioners (OLP):

OLP service is delivered by a Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State Law and in any setting permissible under State practice law. OLP does not require a DSM diagnosis in order for the service to be delivered.

NP-LBHPs include individuals licensed and able to practice independently as a:
- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist: or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individual who are licensed under supervision or direction of a licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:
Licensed Master Social Worker (LMSW)

In Addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS, OR DOH or its designee, in settings permissible by that designation.

Please refer to the “Children’s Health and Behavioral Health Services Transformation-Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services” for addition information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity Criteria

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<thead>
<tr>
<th>Admission to OLP</th>
<th>Continued Stay</th>
<th>Discharge</th>
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LEVEL OF CARE CRITERIA- NEW YORK

CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19
64
<table>
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<tr>
<th>Criteria 1 or 2 must be met:</th>
<th>Criteria 1 OR 2 and 3,4,5,6:</th>
<th>Any one of criteria 1-6 must be met</th>
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<tbody>
<tr>
<td>The child/youth is being assessed by the NP-LBHP to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:</td>
<td>1. The child/youth is making some progress but has not fully reached established service goals and there is expectation that if the child/youth continues to improve, then the service continues OR 2. Continuation of the services is needed to prevent the loss of functional skills already achieved AND 3. The child/youth continues to meet admission criteria AND 4. The child/youth and/or family/caregiver(s) continue to engage in services AND 5. An alternative service(s) would not meet the child/youth needs AND 6. The treatment plan has been appropriately updated to establish or modify ongoing goals.</td>
<td>1. The child/youth no longer meets continued stay criteria OR 2. The child/youth has successfully reached individual/family established service goals for discharge; OR 3. The child/youth or parent/caregiver(s) withdraws consent for services; OR 4. The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR 5. The child/youth is no longer engaged in the service, despite multiple attempts, on the part of the provider to apply reasonable engagement strategies; OR 6. The child/youth and or family/caregiver(s) no longer needs OLP as he/she is obtaining a similar benefit through other services and resources.</td>
</tr>
<tr>
<td>1. Correct or ameliorates conditions that are found through an EPSDT screening; OR 2. Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.</td>
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OLP Limits/Exclusions

Limits/Exclusions:
- Groups must not exceed more than 6-8 members. Consideration may be given to a smaller limit of participants are younger than eight years of age.
- Evidence Based Practice (EBPs) requires prior approval, designation, and fidelity reviews on an ongoing basis as determined necessary by New York State.
- Inpatient hospital facilities are allowed for licensed professionals other than social workers if a Preadmission screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visits and may not be billed separately.
- Visits to Intermediate Care Facilities for individual with Mental Retardation (ICF-MR) are not covered.
- All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid.
- If a child requires medical necessary service that are best delivered in the school setting by a community provider the service needs to be detailed on the treatment plan.
- If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child’s individualized Education Plan (IEP)(504 plan services are not reimbursable by Medicaid).
- Evidence based practice (EBP) requires approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment service must be a part of a treatment plan including goals and activities necessary to correct ameliorates conditions discovered during the initial assessment visits.

Crisis Intervention:
Crisis Intervention (CI) services are provided to children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth’s capabilities and functioning.

The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future.
Please refer to the “Children’s Health and Behavioral Health services Transformation-Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services” for addition information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity Criteria

<table>
<thead>
<tr>
<th>Admission to Crisis Intervention</th>
<th>Continued Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Criteria must be met:</strong></td>
<td>N/A</td>
<td>Any one of criteria 1 or 2 must be met:</td>
</tr>
<tr>
<td>• The child/youth experiencing acute psychological/emotional changes which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral provider, community member) to effectively resolve it; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The child/youth demonstrates at least one of the following:</td>
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<tr>
<td>o Suicidal/assaultive/destructive ideas, threats, plans or actions that represent a risk to self or others; or</td>
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<tr>
<td>o Impairment in mood/thought/behavior disruptive to home, school, or the community or</td>
<td></td>
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<tr>
<td>o Behavior escalating to the extent that a higher intensity or service will likely be required; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The intervention is necessary to further evaluate, resolve, and/or stabilize the; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The services are recommended by the following Licensed Practitioners of the Healing Arts</td>
<td></td>
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</tr>
</tbody>
</table>

1. The child/youth no longer meets admission criteria (demonstrates symptom reduction, stabilization, and restoration, or developing the coping mechanisms to pre-crisis levels of functioning) and/or meets criteria for another level of care. Either more or less intensive; OR

2. The child/youth or parent/caregiver(s) withdraws consent for services
<table>
<thead>
<tr>
<th>Level of Care Criteria</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19</td>
<td></td>
</tr>
</tbody>
</table>

Operating within the scope of their practice under State License:

- Psychiatrist
- Physician
- Licensed Psychoanalyst
- Registered Professional Nurse
- Nurse Practitioner
- Clinical Nurse Specialist
- Licensed Clinical Social worker
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor or
- Licensed Psychologist

**Crisis Intervention Limits/Exclusions**

**Limits/Exclusions**

- Within the 72 hour time-frame of a crisis, de-escalation techniques are utilized in an attempt to calm the child, information is gathered from the child, family, and or other collateral supports on what may have triggered the crisis; information is gathered on the child’s history; review of medication occurs, as appropriate, and a crisis plan is developed with the child/family. Warm handoff to providers of needed services should be occurring following these expectation.

- The following activities are excluded, financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature

- Services may not be primarily educational, vocational, recreational, and or custodial (i.e. for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipients or anyone else’s safety, and could be provided by persons without professional skills or training). Services also do not include services, supplies or procedures performed in a nonconventional setting including, resorts, spas, therapeutic programs, and camps. Once the current crisis episode and follow up exceeds 72 hours, then it shall be considered a new crisis intervention episode or will be transferred to a longer-term service for rehabilitation skill-building such as CPST. An episode is defined as starting with the initial face to face contact with the child.

- The child/youth’s chart must reflect resolution of the crisis, which marks the end of the episode. Warm handoff to follow up service with a developed plan should follow.
Substance Use Should be recognized and addressed in an integrated fashion as it may add to the risk and increase the need for engagement in care. Crisis services cannot be denied based upon substance use. Crisis team members should be trained on screening for substance use disorders.

**Community Psychiatric Supports and Treatment (CPST);** CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth’s treatment plan. This includes the implementation of interventions using evidenced based techniques drawn from cognitive behavioral therapy and/or other evidence based psychotherapeutic interventions approved by New York State.

CPST includes the following components: Rehabilitation Psychoeducation, Intensive Interventions, Strength Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Team Crisis Management

CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitation services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

Please refer to the “Children’s Health and Behavioral Health services Transformation-Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services” for addition information regarding this service. This service is available for children from birth to 21 years of age.

**Guidelines for Medical Necessity**

<table>
<thead>
<tr>
<th>Admission to Community Psychiatric Supports and Treatment</th>
<th>Continued Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>All criteria must be met:</td>
<td></td>
<td>Any one of criteria 1 -6 must be met:</td>
</tr>
<tr>
<td>1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the child/youth is at risk of development of a behavioral health diagnosis; AND</td>
<td>1. The child/youth continues to meet admission criteria; AND</td>
<td>1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more of less intensive; OR</td>
</tr>
<tr>
<td>2. The child/youth shows evidence of engagement towards resolution of symptoms but has not fully reached established service goals and there is expectation that if the</td>
<td>2. The child/youth has successfully met the specific goals outlines in</td>
<td>2. The child/youth has successfully met the specific goals outlines in</td>
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</tbody>
</table>

CMMC Approved: 6/2/17, 10/17/17; R2 QMUMCMC Approved 10/16/18, 1/28/19; NYS Approved: 1/2/19
2. The child/youth is expected to achieve skill restoration in one of the following areas:
   a) Participation in community activities and/or positive peer support networks
   b) Personal relationships
   c) Personal safety and/or self-regulation
   d) Independence/productivity
   e) Daily living skills
   f) Symptom management
   g) Coping strategies and effective functioning in the home, school, social or work environment; AND

3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND

4. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:
   - Licensed Master Social Worker
   - Licensed Clinical Social Worker
   - Licensed Mental Health Counselor
   - Licensed Creative Arts Therapist
   - Licensed Marriage and Family Therapist
   - Licensed Psychoanalyst
   - Licensed Psychologist
   - Physician’s Assistant
   - Psychiatrist

   service continues, the child/youth will continue to improve; AND

3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND

4. The child/youth is at risk of losing skills gained if the service is not continued; AND

5. Treatment planning includes family/caregiver(s) and/or other support systems, unless clinical indicated or relevant

the treatment plan for discharge; OR

3. The child/youth or parent/caregiver(s) withdraws consent for services; OR

4. The child/youth is not making progress on established services goals, nor is there expectation of any progress with continued provision of services; OR

5. The child/youth is no longer engaged in services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR

6. The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other service and resources.
• Physician
• Registered Professional Nurse or
• Nurse Practitioner

CPST Limits/Exclusions

Limits/Exclusions
• The provider agency will assess the child prior to developing a treatment plan for the child
• Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
• A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative services
• Group face-to-face may occur for Rehabilitative Supports
  o Group should not exceed more that 6-8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years of age
• Evidence-Based practices (EBP) requires prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State (Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic, Testing (EPSDT) Services, Appendix D).
  o The institute of medicine (IOM) defines “evidence based practice” as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values (IOM, 2001). Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person’s capacity to cope with or prevent symptom manifestation.

Psychosocial Rehabilitation (PSR):
Psychosocial Rehabilitation Services (PSR) are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth’s behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth’s functional level as possible as necessary for integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth’s individualized treatment plan.
Please refer to the “Children’s Health and Behavioral Health services Transformation-Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services” for additional information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

<table>
<thead>
<tr>
<th>Admission to Psychosocial Rehabilitation</th>
<th>Continued Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All criteria must be met:</strong></td>
<td><strong>All criteria must be met:</strong></td>
<td><strong>Any one of criteria 1 - 6 must be met:</strong></td>
</tr>
<tr>
<td>1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND</td>
<td>1. The child/youth continues to meet admission criteria; AND</td>
<td>1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR</td>
</tr>
<tr>
<td>2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND</td>
<td>2. The child/youth shows evidence of engagement towards resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the child/youth will continue to improve; AND</td>
<td>2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR</td>
</tr>
<tr>
<td>3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth’s functional level to facilitate integration of the child/youth as participant of their community and family AND</td>
<td>3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND</td>
<td>3. The child/youth or parent/caregiver(s) withdraws consent for services; OR</td>
</tr>
<tr>
<td>4. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:</td>
<td>4. The child/youth is at risk of losing skills gained if the service is not continued; AND</td>
<td>4. The child/youth is not making progress or established service goals, nor is there expectation of any progress with continued provision of service; OR</td>
</tr>
<tr>
<td>• Licensed Master Social Worker</td>
<td>5. Treatment planning includes family/caregiver(s) and/or other support systems, unless clinically indicated or relevant</td>
<td>5. The child/youth is no longer engaged in the services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR</td>
</tr>
<tr>
<td>• Licensed Clinical Social Worker</td>
<td></td>
<td>6. The child/youth and or family/caregiver(s) no longer needs</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Physician</td>
<td>Registered Professional Nurse or Nurse Practitioner</td>
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</tbody>
</table>

**PSR Limits/Exclusions**

- The provider agency will assess the child prior to developing a treatment plan for the child. A licensed CPST practitioner or OLP must develop the treatment plan, with the PSR worker implementing the intervention identified on the treatment plan.
- A child with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- Group should not exceed more than 6-8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years old.
- Treatment service must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

**Family Peer Support Services (FPSS):**

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance abuse, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth.

This service is needed to allow the child the best opportunity to remain in the community. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth’s treatment plan.

This service is needed to achieve specific outcome(s) such as: strengthening the family unit, building skills within the family for the benefit of the child, promoting empowerment within the family, and strengthening overall supports in the child’s environment.
Please refer to the “Children’s Health and Behavioral Health services Transformation-Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services” for additional information regarding this service. This service is available for children from birth to 21 years of age.

### Admission to Family Peer Support Services

Criteria 1 OR 2, AND 3 AND 4 AND 5 must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR

2. The child/youth displays demonstrated evidence of skill(s) lost or underdeveloped as a result of the impact of their physical health diagnosis; AND

3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND

4. The child/youth’s family is available, receptive to and demonstrates needs for improvement in the following areas such as but not limited to:
   a) Strengthening the family unit
   b) Building skills within the family for the benefit of the child
   c) Promoting empowerment within the family
   d) Strengthening overall supports in the child’s environment; AND

5. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:

### Continued Stay

All criteria must be met:

1. The child/youth continues to meet admission criteria; AND

2. The child/youth is making progress but has not fully reached established service goals and there is a reasonable expectation that continued service will increase the child/youth meeting service goals; AND

3. Family/caregiver(s) participation in treatment is adequate to meaningfully contribute to the child/youth’s progress in achieving service goals; AND

4. Additional psychoeducation or training to assist the family care/giver understanding the child’s progress and treatment or to care for the child would contribute to the child/youth's progress; AND

5. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND

### Discharge

Any one of criteria 1 - 6 must be met:

1. The child/youth and/or family no longer meets admission criteria OR

2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR

3. The family withdraws consent for services; OR

4. The child/youth and/or family is not making progress on an established service goal, nor is there expectation of any progress with continued provision of services; OR

5. The child/youth and/or family is no longer engaged in the services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
| Licensed Master Social Worker | 6. The child/youth is at risk of losing skills gained if the service is not continue; AND |
| Licensed Clinical Social Worker | 7. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant |
| Licensed Mental Health Counselor | |
| Licensed Creative Arts Therapist | |
| Licensed Marriage and Family Therapist | |
| Licensed Psychoanalyst | |
| Licensed Psychologist | |
| Physician’s Assistant | |
| Psychiatrist | |
| Physician | |
| Registered Professional Nurse or | |
| Nurse Practitioner | |

### FPSS Limits/Exclusions

Limits/exclusions:
- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit.
- A child with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
- A group cannot exceed more than 12 individuals in total.
- The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing a note occurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family, and providers and include a reevaluation of plan to determine whether service have contributed to meeting the stated goals. A new intervention plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services.

Medicaid family support programs will not reimburse for the following:
- 12-step groups run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services, community education service, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary
- Time spent doing, attending, or participating in recreational activities
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, a teacher’s aide, or an academic tutor
- Time spent attending school (e.g. during a day treatment program)
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings
- Child care services or services provided as a substitute for the parent or other individual responsible for providing care and supervision
- Respite care
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation
- Services not identified on the beneficiary authorized treatment plan
- Service not in compliance with the service manual and not in compliance with State Medicaid standards
- Services provided to children, spouses, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary’s life to address problems not directly related to the eligible beneficiary’s issues and not listed on the eligible beneficiary’s treatment plan
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed

**Youth Peer Support and Training (YPST):**

Youth peer support and training (YPST) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school placement, and or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills.

Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth’s individualized treatment plan.
The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.

Please refer to the “Children's Health and Behavioral Health services Transformation-Medicaid State Plan Provider Manual for Children’s BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services” for addition information regarding this service. This service is available for children from birth to 21 years of age.

Guidelines for Medical Necessity

<table>
<thead>
<tr>
<th>Admission to Youth Peer Support Training</th>
<th>Continued Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria 1 OR 2, AND 3, 4, 5, 6 must be met:</strong></td>
<td><strong>All criteria must be met:</strong></td>
<td><strong>Any of criteria 1 -6 must be met:</strong></td>
</tr>
<tr>
<td>1. The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; OR</td>
<td>1. The youth continues to meet admission criteria; AND</td>
<td>1. The youth no longer meets admission criteria OR</td>
</tr>
<tr>
<td>2. The youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND</td>
<td>2. The youth shows evidence of engagement towards resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the youth will continue to improve; AND</td>
<td>2. The youth has successfully met the specific goals outlined in the treatment plan for discharge; OR</td>
</tr>
<tr>
<td>3. The youth requires involvement of a youth peer advocate to implement the intervention(s) outlines in the treatment plan, AND</td>
<td>3. The youth does not require an alternative and/or higher, more intensive level of care or treatment; AND</td>
<td>3. The youth or parent/caregiver withdraws consent for services; OR</td>
</tr>
<tr>
<td>4. The youth demonstrates a need for improvement in the following areas such as but not limited to</td>
<td>4. The youth is at risk for losing skills gained if the service is not continued; AND</td>
<td>4. The youth is not making progress on an established service goals, nor is there expectation of any progress with continued provision of services; OR</td>
</tr>
<tr>
<td>a) Enhancing youth’s abilities to effectively manage comprehensive health needs</td>
<td>5. Treatment planning includes family/caregiver(s) and/or other</td>
<td>5. The youth is no longer engaged in the services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR</td>
</tr>
<tr>
<td>b) Maintaining recovery</td>
<td></td>
<td>6. The youth no longer needs this service as they are obtaining similar</td>
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<tr>
<td>c) Strengthening resiliency, self-advocacy</td>
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<td>d) Self-efficacy and empowerment</td>
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<tr>
<td>e) Developing competency to utilize resources and supports in the community</td>
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<tr>
<td>f) Transition into adulthood or participates in treatment</td>
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<td>; AND</td>
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</tbody>
</table>
5. The youth is involved in the admission process and help determine service goals; AND

6. The Youth is available and receptive to receiving this service; AND

7. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:
   - Licensed Master Social Worker
   - Licensed Clinical Social Worker
   - Licensed Mental Health Counselor
   - Licensed Creative Arts Therapist
   - Licensed Marriage and Family Therapist
   - Licensed Psychoanalyst
   - Licensed Psychologist
   - Physician’s Assistant
   - Psychiatrist
   - Physician
   - Registered Professional Nurse or
   - Nurse Practitioner

support systems, unless not clinically indicated

benefit through other services and resources

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YPTS Limits/Exclusions

Limits/exclusions:
- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
• A youth with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service
• A group is composed of 2 or more youths and cannot exceed more than 12 individuals in total
• The intervention plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing a note occurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family, and providers and include a reevaluation of plan to determine whether service have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services

Medicaid family support programs will not reimburse for the following
• 12-step groups run by peers
• General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services, community education service, such as health presentations to community groups, PTAs, etc.
• Contacts that are not medically necessary
• Time spent doing, attending, or participating in recreational activities
• Services provided to teach academic subjects or as a substitute for educational personal such as, but not limited to, a teacher, a teacher’s aide, or an academic tutor
• Time spent attending school (e.g. during a day treatment program)
• Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings
• Child care services or services provided as a substitute for the parent or other individual responsible for providing care and supervision
• Respite care
• Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation
• Services not identified on the beneficiary authorized treatment plan
• Service not in compliance with the service manual and not in compliance with State Medicaid standards
• Services provided to children, spouses, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary’s life to address problems not directly related to the eligible beneficiary’s issues and not listed on the eligible beneficiary’s treatment plan
• Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed

State Assurance

The state assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a)(13) of the Act.

• Educational
• Room and board
• Habilitation services
• Service to inmates in public institutions as defined in 42 CFR 435.1010;
• Services to individuals residing in institutions for mental disease as described in 42 CFR 435.1010
• Recreational and social activities
• Services that must be covered elsewhere in the state Medicaid plan