

BEACON HEALTH OPTIONS / NEW YORK LEVEL OF CARE CRITERIA

LEVEL OF CARE CRITERIA

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

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

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

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

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.

SECTION I: INPATIENT BEHAVIORAL HEALTH

Overview

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

A. NMNC 1.101.0 Inpatient Psychiatric Services

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

A. NMNC 1.101.0 Inpatient Psychiatric Services

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1-4 must be met and either 5 or 6; criteria 7 and 8 as applicable. For Eating Disorders 10-13 must also be met:</p> <ol style="list-style-type: none"> 1) Symptoms consistent with a DSM or corresponding ICD diagnosis 2) Member's psychiatric condition requires 24-hour medical/psychiatric and nursing services and of such intensity that needed services can only be provided in an acute psychiatric hospital. 	<p>All of the following criteria 1 - 10 must be met; For Eating Disorders, criterion 11 or 12 must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria; 2) Another less restrictive Level of Care would not be adequate to administer care. 3) Member is experiencing symptoms of such intensity that if discharged, s/he 	<p>Any one of the following: Criteria 1, 2, 3, or 4; criteria 5 and 6 are recommended, but optional. For Eating Disorders, criteria 8 - 10 must be met:</p> <ol style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive.

<p>3) Inpatient psychiatric services are expected to significantly improve the member's psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical/psychiatric and nursing services will no longer be needed.</p> <p>4) Symptoms do not result from a medical condition that would be more appropriately treated on a medical/surgical unit.</p> <p>One of the following must also be present:</p> <p>5) Danger to self or</p> <p>6) A serious suicide attempt by degree of lethality and intentionality</p> <ol style="list-style-type: none"> a) Suicidal ideation with plan and means available and/or history of prior serious suicide attempt; b) Suicidal ideation accompanied by severely depressed mood, significant losses, and/or continued intent to harm self; c) Command hallucinations or persecutory delusions directing self-harm; d) Loss of impulse control resulting in life-threatening behavior or danger to self; e) Significant weight loss within the past three months; f) Self-mutilation that could lead to permanent disability; g) Uncontrolled risk taking behaviors h) Homicidal ideation and/or indication of actual or potential danger to others; <ol style="list-style-type: none"> i. Command hallucinations or persecutory delusions directing harm or potential violence to others; ii. Indication of danger to property evidenced by credible threats of destructive acts 	<p>would likely require rapid re-hospitalization;</p> <p>4) Treatment is still necessary to reduce symptoms and improve functioning so that the member may be treated in a less restrictive Level of Care.</p> <p>5) 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;</p> <p>6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. Treatment plan has been updated to address non-adherence.</p> <p>7) The member is actively participating in plan of care and treatment to the extent possible consistent with his/her condition</p> <p>8) Family/guardian/caregiver is participating in treatment as appropriate.</p> <p>9) There is documentation of coordination of treatment with state or other community agencies, if involved.</p> <p>10) Coordination of care and active discharge planning are ongoing, beginning at admission, with goal of transitioning the member to a less intensive Level of Care.</p> <p>For Eating Disorders:</p> <p>11) Member has had no appreciable weight gain (<2lbs/wk.)</p> <p>12) Ongoing medical or refeeding complications.</p>	<p>2) Member or parent/guardian withdraws consent for treatment <u>and/or</u> member does not meet criteria for involuntary or mandated treatment.</p> <p>3) Member does not appear to be participating in the treatment plan.</p> <p>4) Member is not making progress toward goals, nor is there expectation of any progress.</p> <p>5) Member's individual treatment plan and goals have been met.</p> <p>6) Member's support system is aware and in agreement with the aftercare treatment plan.</p> <p>7) Member's physical condition necessitates transfer to a medical facility.</p> <p>For Eating Disorders:</p> <p>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).</p> <p>9) No re-feeding is necessary</p> <p>10) All other psychiatric disorders are stable.</p>
---	---	---

<p>iii. Documented or recent history of violent, dangerous, and destructive acts</p> <p>7) Indication of impairment/disordered/bizarre behavior impacting basic activities of daily living, social or interpersonal, occupational and/or educational functioning;</p> <p>8) Evidence of severe disorders of cognition, memory, or judgment are not associated with a primary diagnosis of dementia or other cognitive disorder. (e.g. acute psychotic symptoms)</p> <p>9) Severe comorbid substance use disorder is present and must be controlled (e.g. abstinence necessary) to achieve stabilization of primary psychiatric disorder</p> <p>For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge</p> <p>10) DSM or corresponding ICD diagnosis and symptoms consistent with a primary diagnosis of Eating Disorder</p> <p>11) Member has at least one of the following:</p> <p>a) Psychiatric, behavioral, and eating disorder symptoms that are expected to respond to treatment in an Acute Level of Care</p> <p>b) Symptomatology that is not responsive to treatment in a less intensive Level of Care.</p> <p>c) An adolescent with newly diagnosed anorexia;</p> <p>12) Member requires 24-hour monitoring, which includes: before, after, and during meals; evening to monitor behaviors (i.e. restricting, bingeing/purging, over-exercising, use of laxatives or diuretics);</p> <p>13) Member exhibits physiological instability requiring 24- hour monitoring for at least one (1) of the following:</p>		
---	--	--

- 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 (i.e. Potassium < 3)
- b) Physiological liability (i.e. Significant postural hypotension, bradycardia, CHF, cardiac arrhythmia);
- c) Change in mental status;
- d) Body temperature below 96.8 degrees;
- e) Severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement;
- f) Acute gastrointestinal dysfunction (i.e. Esophageal tear secondary to vomiting, mega colon or colonic damage, self-administered enemas);
- g) Heart rate is less than 40 beats per minute for adults or near 40 beats per minute for children

Exclusions

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

- 1) The individual can be safely maintained and effectively treated at a less intensive level of care.
- 2) Symptoms result from a medical condition which warrants a medical / surgical setting for treatment.
- 3) The individual exhibits serious and persistent mental illness **and** is not in an acute exacerbation of the illness.
- 4) The primary problem is social, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or

admission is being used as an alternative to incarceration.		
---	--	--

Inpatient Substance Use Disorder Services –

Per the OASAS LOCADTR 3.0 Manual 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 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 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.

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 3.301.0 Partial Hospitalization Program and Outpatient Day Rehabilitation**
- C. NMNC 3.302.0 Intensive Outpatient Treatment**

- D. Continuing Day Treatment**
- E. Intensive Psychiatric Rehabilitation Treatment (IPRT)**
- F. Residential Treatment Service (RTS)**

A. Ambulatory Detoxification

Per the OASAS LOCADTR 3.0 Manual 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 3.301.0 Partial Hospitalization Program

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 7 days per week. 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.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
--------------------	-------------------------	--------------------

<p>All of the following criteria 1 - 8 must be met; For Eating Disorders, criteria 9 – 10 must also be met:</p> <ol style="list-style-type: none"> 1) Symptoms consistent with a DSM or corresponding ICD diagnosis; 2) The member manifests a significant or profound impairment in daily functioning due to psychiatric illness. 3) Member has adequate behavioral control and is assessed not to be an immediate danger to self or others requiring 24-hour containment or medical supervision. 4) Member has a community-based network of support and/or parents/caretakers who are able to ensure member’s safety outside the treatment hours. 5) Member requires access to a structured treatment program with an on-site multidisciplinary team, including routine psychiatric interventions for medication management. 6) Member can reliably attend and actively participate in all phases of the treatment program necessary to stabilize their condition. 7) The severity of the presenting symptoms is not able to be treated safely or adequately in a less intensive level of care. 8) Member has adequate motivation to recover in the structure of an ambulatory treatment program. <p>For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge</p> <ol style="list-style-type: none"> 9) Member requires admission for Eating Disorder Treatment and requires at least one of the following: 	<p>All of the following criteria 1 - 7 must be met; For Eating Disorders, criterion 8 must also be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria; 2) Another less intensive level of care would not be adequate to administer care. 3) Treatment is still necessary to reduce symptoms and increase functioning so the member may be treated in a less intensive level of care. 4) Member’s progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6) Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 7) Coordination of care and active discharge planning are ongoing, with goal of transitioning member to a less intensive Level of Care. <p>For Eating Disorders:</p> <ol style="list-style-type: none"> 8) Member has had no appreciable stabilization of weight since admission; 	<p>Any one of the following: Criteria 1, 2, 3, or 4; criteria 5 – 6 are recommended, but optional; For Eating Disorders, criterion 7 is also appropriate:</p> <ol style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment. 3) Member does not appear to be participating in treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member’s individual treatment plan and goals have been met. 6) Member’s support systems are in agreement with the aftercare treatment plan. <p>For Eating Disorders:</p> <ol style="list-style-type: none"> 7) Member has been adherent to the Eating Disorder related protocols, medical status is stable and appropriate, and the member can now be managed in a less intensive level of care.
---	--	--

<p>a) Weight stabilization: generally, between 80 and 85% of IBW (or BMI 15-17) with no significant co-existing medical conditions (see IP #14)</p> <p>b) Continued monitoring of corresponding medical symptoms;</p> <p>c) Reduction in compulsive exercising or other repetitive eating disordered behaviors that negatively impacts daily functioning.</p> <p>10) Any monitoring of member's condition when away from partial hospital program can be provided by family, caregivers, or other available resources.</p> <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1) The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required. 2) The individual does not voluntarily consent to admission or treatment or does not meet criteria for involuntary admission to this level of care. 3) The individual has medical conditions or impairments that would prevent beneficial utilization of services. 4) The individual exhibits a serious and persistent mental illness consistent throughout time and is not in an acute exacerbation of the mental illness. 5) The individual requires a level of structure and supervision beyond the scope of the program (i.e. considered a high risk for non-compliant behavior and/or elopement). 	<p>9) Other eating disorder behaviors persist and continue to put the member's medical status in jeopardy.</p>	
--	--	--

6) The individual can be safely maintained and effectively treated at a less intensive level of care.		
---	--	--

Partial Hospitalization Substance Use Disorder Services and Outpatient Day Rehabilitation

Per the OASAS LOCADTR 3.0 Manual 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 3.302.0 Intensive Outpatient Treatment

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. 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.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1-8 must be met: For Eating Disorders, criteria 9-10 must be met</p> <ol style="list-style-type: none"> 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. 8) Needed type or frequency of treatment is not available in or is not appropriate for delivery in an office or clinic setting <p>For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge</p>	<p>All of the following criteria 1-9 must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria. 2) Another less intensive level of care would not be adequate to administer care; 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely require a more intensive level of care. 4) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less intensive level of care; 5) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6) Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress towards clearly defined and measurable goals; 7) Family/guardian/caregiver is participating in treatment as appropriate. 8) There is documentation around coordination of treatment with all involved parties including state/community agencies when appropriate; 9) The provider has documentation supporting discharge planning attempts to transition the member to a less intensive level of care. 	<p>Any one of the following: Criteria 1, 2, 3, or 4; criteria 5 – 6 are recommended, but optional:</p> <ol style="list-style-type: none"> 1) Member no longer meet admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or guardian withdraws consent for treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan.

<p>9) Member requires admission for Eating Disorder Treatment and requires at least one of the following:</p> <ul style="list-style-type: none"> a) Weight stabilization: generally, between 80 and 85% of IBW (or BMI of 15-17 or more) with no significant co- existing medical conditions (see IP #14) b) Continued monitoring of corresponding medical symptoms; c) Reduction in compulsive exercising or other repetitive eating disordered behaviors that negatively impacts daily functioning. <p>10) Any monitoring of member's condition when away from intensive outpatient program can be provided by family, caregivers, or other available resources.</p> <p>Exclusions</p> <p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ul style="list-style-type: none"> 1) The individual is a danger to self and others or sufficient impairment exists that a more intensive level of service is required. 2) The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications. 3) The individual requires a level of structure and supervision beyond the scope of the program. 4) The individual can be safely maintained and effectively treated at a less intensive level of care. 		
--	--	--

<p>5) The primary problem is social, economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.</p> <p>6) The main purpose of the admission is to provide structure that may otherwise be achieved via community based or other services to augment vocational, therapeutic or social activities.</p>		
--	--	--

Intensive Outpatient Substance Use Disorder Services –

Per the OASAS LOCADTR 3.0 Manual 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

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.).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1 – 7 must be met:</p> <ol style="list-style-type: none"> 1) Symptoms consistent with a DSM or ICD diagnosis. 2) Member’s exacerbation or longstanding psychiatric disorder and level of functioning requires daily support and structure; 3) The member has the motivation and capacity to participate and benefit from day treatment. 4) Treatment at a less intensive level of care would contribute to an exacerbation of symptoms. 5) Member is assessed to be at risk of requiring a higher level of care if not engaged in day treatment services. 6) Member/guardian is willing to participate in treatment voluntarily 7) Member’s psychiatric/substance use/biomedical condition is sufficiently stable to be managed in a day treatment setting. <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 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. 	<p>All of the following criteria 1 – 6 must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria. 2) Another less intensive level of care would not be adequate to administer care. 3) Treatment is still necessary to reduce symptoms and increase functioning for the member to be transitioned to a less restrictive setting. 4) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5) Family/guardian is participating in treatment as clinically indicated. 6) Coordination of care and active discharge planning are ongoing. 	<p>Any one of the following: Criteria 1, 2, 3, or 4; criteria 5 – 6 are recommended, but optional:</p> <ol style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member or guardian withdraws consent for treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member’s individual treatment plan and goals have been met. 6) Member’s support system is in agreement with the aftercare treatment plan.

<p>5) The individual has medical conditions or impairments that would prevent beneficial utilization of services.</p> <p>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</p>		
--	--	--

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.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
--------------------	-------------------------	--------------------

<p>All of the following criteria 1 – 4 must be met:</p> <ol style="list-style-type: none"> 1) DSM or corresponding ICD diagnosis 2) Member has adequate capacity to participate in and benefit from this treatment. 3) Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4) Member is assessed to be at risk of requiring higher levels of care if not engaged in IPRT treatment. 	<p>All of the following criteria 1 – 2 must be met:</p> <ol style="list-style-type: none"> 1) The member continues to meet admission criteria 2) One of the following is present: <ol style="list-style-type: none"> a) The member has an active goal and shows progress toward achieving it. b) The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c) The member requires a IPRT level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without IPRT services; and the individual would require a higher level of care. 	<p>Any one of the following: Criteria 1, 2, 3, 4, 5, or 6:</p> <ol style="list-style-type: none"> 1) The member no longer meets PRS level-of care criteria. 2) The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated. 3) The member has achieved current recovery goals and can identify no other goals that would require additional IPRT services in order to achieve those goals. 4) The member is not participating in a recovery plan and is not making progress toward any goals. 5) Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6) The member can live, learn, work and socialize in the community with supports from natural and/or community resources.
--	---	---

F. NMNC 2.202.03 Residential Treatment Services

Residential Treatment Services (RTS) Residential Treatment Services (also known as a Residential Treatment Center) are 24-hours, 7 days a week facility-based programs that provide individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming, such as group, CBT, DBT and motivational interviewing, within a milieu with a high degree of supervision and structure and is intended for members who do not need the high 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 the least restrictive environment to allow for stabilization and integration. Consultations and psychological testing, as well as routine medical care, are included in the per diem rate. RTSs serve members who have sufficient potential to respond to active treatment, need a protected and structured environment, and for whom outpatient, partial hospitalization, or acute hospital inpatient treatments are not appropriate. Realistic discharge goals should be set upon admission, and full participation in treatment by the member and his or her family members, as well as community-based treatment providers is expected when appropriate. Physician evaluation and re-evaluations are based on each individual member’s clinical needs.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>Criteria 1 – 9 must be met for all; Criteria 10, when applicable. For Eating Disorders, criteria 9-13 must also be met:</p> <ol style="list-style-type: none"> 1) DSM or corresponding ICD diagnosis and must have a mood, thought, or behavior disorder which requires, and can reasonably be expected to respond to therapeutic interventions 2) The 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. 3) The member may not be appropriate for a different level of care as evidenced by a series of increasingly dangerous behaviors which present significant risk 4) Member has sufficient cognitive capacity to respond to active, intensive and time-limited psychological treatment and intervention. 5) Severe deficit in ability to perform self-care activity is present (i.e. self-neglect with inability to provide for self at a lower level of care). 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. 	<p>Criteria 1 – 11 must be met for all; For Eating Disorders criteria 12 and 13 must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria; 2) Another less restrictive level of care would not be adequate to provide needed containment and administration of care. 3) Member is experiencing symptoms of such intensity that if discharged, s/he would likely be readmitted; 4) Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive level of care. 5) There is evidence of progress towards resolution of the symptoms that are causing a barrier to treatment in a less restrictive level of care 6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out 7) Member evaluation by physician occurs on an at least weekly basis 8) Member's progress is monitored regularly and the treatment plan is modified, if the member is not making progress towards a set of clearly defined and measurable goals. 9) Member is engaged in treatment and amenable to 	<p>Criteria 1, 2, 3, or 4 are suitable; criteria 5 and 6 are recommended, but optional; For Eating Disorders, criterion 7 must be met:</p> <ol style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another level of care, more or less intensive. 2) Member or parent/guardian withdraws consent for treatment and the member does not meet criteria for involuntary/mandated treatment. 3) Member does not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan. <p style="text-align: center;">For Eating Disorders:</p> <ol style="list-style-type: none"> 7) 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.

<p>7) Member requires a time-limited period for stabilization and community reintegration.</p> <p>8) When appropriate, family/guardian/caregiver agree to participate actively in treatment as a condition of admission.</p> <p>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.</p> <p>10) Severe comorbid substance use disorder is present that must be controlled (e.g., abstinence necessary) to achieve stabilization of primary psychiatric disorder.</p> <p>For Eating Disorders: * weight alone should not be the sole criteria for admission or discharge</p> <p>11) Weight stabilization: generally, <85% of IBW (or BMI of 15 or less, with no significant co-existing medical conditions)</p> <p>12) Member is medically stable and does not require IV fluids, tube feedings or daily lab tests.</p> <p>13) Member has had a recent significant weight loss and cannot be stabilized in a less restrictive level of care.</p> <p>14) Member needs direct supervision at all meals and may require bathroom supervision for a time period after each meal.</p> <p>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.</p> <p>Exclusions:</p>	<p>goals/interventions set forth by treatment team.</p> <p>10) Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate or engagement is underway.</p> <p>11) There must be evidence of coordination of care and active discharge planning to:</p> <ul style="list-style-type: none"> a. Transition the member to a less intensive level of care; b. Operationalize how treatment gains will be transferred to subsequent level of care. <p>For Eating Disorders:</p> <p>12) Member continues to need supervision for most if not all meals and/or use of bathroom after meals.</p> <p>13) Member has had no appreciable weight gain since admission.</p>	
---	---	--

<p>Any of the following criteria is sufficient for exclusion from this level of care:</p> <ol style="list-style-type: none"> 1) Member's IBW is < 75% (or BMI of 14 or less) 2) The individual exhibits severe suicidal, homicidal or acute mood symptoms/thought disorder, which requires a more intensive level of care. 3) The individual does not voluntarily consent to admission or treatment. 4) The individual can be safely maintained and effectively treated at a less intensive level of care. 5) The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications. 6) The 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. 		
--	--	--

Residential Treatment Services Substance Use Disorder –

Per the OASAS LOCADTR 3.0 Manual 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 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.

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 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 5.501.02 Outpatient Professional Services**
- B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)**
- C. NMNC 6.604.0 Applied Behavioral Analysis**
- D. Developmental Screening**
- E. NMNC 5.502.0 Psychological and Neuropsychological Testing**
- F. NMNC 5.503.01 Biofeedback**

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

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

A. NMCNC 5.501.02 Outpatient Professional Services

Outpatient Behavioral Health treatment is an essential component of a comprehensive health care delivery system. Individuals with a major mental illness, chronic and acute medical illnesses, substance use disorders, family problems, and a vast array of personal and interpersonal challenges can be assisted in coping with difficulties through comprehensive outpatient treatment. The goal of outpatient behavioral health treatment is restoration, enhancement, and/or maintenance of a member's level of functioning and the alleviation of symptoms that significantly interfere with functioning. The goals, frequency, and length of treatment will vary according to the needs and symptomatology of

the member. Efficiently designed outpatient behavioral health interventions help individuals and families effectively cope with stressful life situations and challenges. Accordingly, best practice includes preparing the member with a plan or process for managing emergencies or symptoms that may escalate between treatment sessions, including after-hours, (e.g. availability of on-call service, community crisis intervention services). Telehealth services are services that can be provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating site) and a provider at a remote location (i.e. distant site). Outpatient Professional Services do not require prior authorization.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1-8 must be met:</p> <ol style="list-style-type: none"> 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 <u>least one of the following</u>: <ol style="list-style-type: none"> 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 (i.e. self-care, occupational, school, or social function). 3) There is an expectation that the individual: <ol style="list-style-type: none"> a) Has the capacity to make significant progress towards treatment goals; b) Requires treatment to maintain current level of functioning; c) Has the ability to reasonably respond and participate in therapeutic intervention. d) Would be at risk to regress and require a more intensive level of care 4) The member does not require a more intensive level of structure beyond the scope of non-programmatic outpatient services. 	<p>All of the following criteria 1- 10 must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria. 2) Member does not require a more intensive level or care, and no less intensive level of care would be appropriate to meet the member's needs. 3) Evidence suggests that the identified problems are likely to respond to current treatment plan; 4) Member's progress is monitored regularly, and the treatment plan is modified, if member is not making substantial progress toward a set of clearly defined and measurable goals. 5) Treatment planning includes family or other support systems unless not clinically indicated. 6) The treatment plan is tailored to address the individual needs of the member: based upon assessment and reassessment throughout treatment, informed by objective outcome measurements (e.g. rating scales) that assess the member's response to treatment. The treatment plan is modified based on member's progress in or response to care. 	<p>Criteria 1 and any one of 2 – 10 must be met:</p> <ol style="list-style-type: none"> 1) The precipitating factors leading to admission have been resolved or ameliorated such that the member no longer needs care. 2) Member has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others. 3) Member no longer meets admission criteria, or meets criteria for a less or more intensive level of care. 4) Member has substantially met the specific goals outlined in treatment plan (there is resolution or acceptable reduction in target symptoms that necessitated treatment). 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

<p>5) Medication management is not sufficient to stabilize or maintain member's current functioning;</p> <p>6) The member is likely to benefit from and respond to psychotherapy due to diagnosis, history, or previous response to treatment;</p> <p>7) The member cannot be adequately stabilized in a rehabilitative, or community, service setting to assist with: health, social, occupational, economic, or educational issues.</p> <p>8) Treatment is not being sought as an alternative to incarceration.</p> <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <p>1) The individual requires a level of structure and supervision beyond the scope of non-programmatic outpatient services</p> <p>2) The individual has medical conditions or impairments that would prevent beneficial utilization of services</p> <p>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.</p> <p>4) Treatment plan is designed to address goals other than the treatment of active symptoms of DSM or corresponding ICD diagnosis (e.g. self-actualization).</p> <p>5) Rehabilitative or community services are provided and are adequate to stabilize or assist the individual in resuming prior level of roles and responsibility.</p>	<p>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.</p> <p>8) Evidence exists that member is at current risk of a higher level of care if treatment is discontinued.</p> <p>9) When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner.</p> <p>10) There is documented active discharge planning from the beginning of treatment.</p>	<p>ineffective or unsafe despite multiple documented attempts to address non-participation issues.</p> <p>6) Evidence does not suggest that the defined problems are likely to respond to continued outpatient treatment.</p> <p>7) Member is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment approach.</p> <p>8) Current treatment plan is not sufficiently goal oriented and focused to meet behavioral objectives.</p> <p>9) 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.</p> <p>10) It is reasonably predicted that maintaining stabilization can occur with discharge from care and/or Medication Management only and community support.</p>
--	--	---

6) Treatment is primarily for the purpose of supportive, respite, social, custodial care.		
---	--	--

Substance Use Outpatient Services –

Per the OASAS LOCADTR 3.0 Manual 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, Opioid Treatment Programs (OTP) 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 and 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)

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1 - 5 must be met; and at least one of criteria 6 – 7 must also be met:</p> <ol style="list-style-type: none"> 1) Member must have a DSM or corresponding ICD diagnosis of a psychiatric disorder. 2) Member can be maintained adequately and safely in their home environment. 3) Member has the capacity to engage and benefit in treatment. 4) Member agrees to participate in psychiatric home based treatment. 5) Member's level of functioning in areas such as self-care, work, family living, and social relations is impaired. 6) Member has social/emotional barriers that cannot be adequately managed in an office based program setting. 7) Member has history of non-compliance in terms of routine office based services which has recently resulted in placement in a more intensive LOC. <p>For HBTP, at least one from Criteria 8 through 11 must also be met:</p> <ol style="list-style-type: none"> 8) History of 2 or more admissions in less than 12 months 9) Presence of co-occurring medical and BH disorders. 10) First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression) 11) History of treatment non- which has resulted in poor functionality in the community 	<p>All of the following criteria 1 - 6 must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria and another less intensive LOC is not appropriate. 2) Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC. 3) Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 4) Member appears to be benefiting from the service. 5) Member is compliant with treatment plan and continues to be motivated for services. 6) Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC 	<p>Any one of the following: Criteria 1, 2, 3 or 4; Criteria 5 – 6 are recommended, but optional:</p> <ol style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment. 3) Member and/or parent/caregiver do not appear to be participating in the treatment plan. 4) Member is not making progress toward goals, nor is there expectation of any progress. 5) Member's individual treatment plan and goals have been met. 6) Member's support system is in agreement with the aftercare treatment plan.

C. NMNC 6.604.0 Applied Behavioral Analysis

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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 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; 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; 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) which result(s) in significant impairment in one or more of the following: <ol style="list-style-type: none"> a) personal care b) psychological function c) vocational function d) educational performance 	<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria; 2) There is no other level of care that would more appropriately address member's needs; 3) Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated in a less restrictive level of care; 4) Treatment/intervention plan includes age appropriate, clearly defined behavioral interventions with measurable goals to target problematic behaviors; 	<p>Any one of the following criteria must be met:</p> <ol style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another level of care; 2) Member's individual treatment plan and goals have been met; 3) Parent / guardian / caregiver is capable of continuing the behavioral interventions; 4) Parent/guardian withdraws consent for treatment; 5) Member is not making progress toward goals, nor is there any expectation of progress;

<p>e) social function f) communication disorders</p> <p>4) The member can be adequately and safely maintained in their 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</p> <p>5) The member's challenging behavior(s) and/or level of functioning is expected to improve with IBI/ABA</p> <p>6) The member is not currently receiving any other in home or office-based IBI/ABA services.</p> <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <p>1) The individual has medical conditions or impairments that would prevent beneficial utilization of services.</p> <p>2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting.</p> <p>3) The following services are not included within the ABA treatment process and will not be certified:</p> <p>a) Speech therapy (may be covered separately under health benefit)</p> <p>b) Occupational therapy (may be covered separately under health benefit)</p> <p>c) Physical Therapy</p> <p>d) Vocational rehabilitation (may be covered separately under health benefit)</p> <p>e) Supportive respite care</p> <p>f) Recreational therapy</p> <p>g) Orientation and mobility</p> <p>h) Respite care</p> <p>i) Equine therapy/Hippo therapy</p> <p>j) Dolphin therapy</p> <p>k) Other educational services</p>	<p>5) Member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward 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;</p> <p>6) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out;</p> <p>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;</p> <p>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;</p>	<p>6) Member's support system is in agreement with the transition / discharge treatment plan;</p>
---	--	---

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 5.502.0 Psychological and Neuropsychological Testing

Psychological and neuropsychological testing is the use of standardized assessment tools to gather information relevant to a member's intellectual, cognitive, and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall psychological and neuropsychological functioning. Test results may have important implications for diagnosis and 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. Neurology consult may be required prior to request.
- All tasks involving **projective testing** must be performed by a licensed psychologist or other licensed clinician with specialized training in projective testing and who is permitted by state licensure.
- The expectation is that diagnosis of ADHD can be made by a psychiatric consult and may not require psychological testing
- Testing requested by the legal or school system is not generally a covered benefit, unless specified by state regulations or account-specific arrangements

Admission Criteria	Criteria for Tests	Non-Reimbursable Tests
<p>All of the following criteria must be met:</p> <p>Psychological Testing 1-3 must be met:</p> <ol style="list-style-type: none"> 1) Request for testing is based on need for at least one of the following: <ol style="list-style-type: none"> a) Differential diagnosis of mental health condition unable to be completed by traditional assessment; b) Diagnostic clarification due to a recent change in mental status for appropriate level of care determination / treatment needs due to lack of standard treatment response. 2) Repeat testing needed as indicated by ALL of the following: 	<ol style="list-style-type: none"> 1) Tests must be published, valid, and in general use as evidenced by their presence in the current edition of <u>Tests in Print IX</u>, or by their conformity to the <i>Standards for Educational and Psychological Tests</i> of the American Psychological Association. 2) Tests are administered individually and are tailored to 	<ol style="list-style-type: none"> 1) Self-rating forms and other paper and pencil instruments, unless administered as part of a comprehensive battery of tests, (e.g., <i>MMPI</i> or <i>PIC</i>) as a general rule. 2) Group forms of intelligence tests. 3) Short form, abbreviated, or “quick” intelligence tests administered at the same time as the <i>Wechsler</i> or <i>Stanford-Binet</i> tests. 4) A repetition of any psychological test or tests provided to the same

<ul style="list-style-type: none"> a) Proposed repeat psychological testing can help answer question that medical, neurologic, or psychiatric evaluation, diagnostic testing, observation in therapy, or other assessment cannot. b) Results of proposed testing are judged to be likely to affect care or treatment of member (i.e. contribute substantially to decision of need for or modification to a rehabilitation or treatment plan). c) Member is able to participate as needed such that proposed testing is likely to be feasible (i.e. appropriate mental status, intellectual abilities, language skills). d) No active substance use, withdrawal, or recovery from recent chronic use and e) Clinical situation appropriate for repeat testing as indicated by 1 or more of the following: <ul style="list-style-type: none"> i. Clinically significant change in member's status (i.e., worsening or new symptoms or findings) ii. Other need for interval reassessment that will inform treatment plan <p>3) The member must have:</p> <ul style="list-style-type: none"> a) Diagnostic evaluation (including psychosocial functioning), unless subject to state regulation or account-specific arrangements. b) No active withdrawal and/or substance misuse within 2 months of request <p>4) The member is experiencing cognitive impairments;</p> <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ul style="list-style-type: none"> 1) Testing is primarily to guide the titration of medication. 	<p>the specific diagnostic questions of concern.</p>	<p>member within the preceding six months, unless documented that the purpose of the repeated testing is to ascertain changes:</p> <ul style="list-style-type: none"> a) Following such special forms of treatment or intervention such as ECT; b) Relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. <p>5) Tests for adults that fall in the educational arena or in the domain of learning disabilities.</p> <p>6) Testing that is mandated by the courts, Department of Children's Services or other social/legal agency in the absence of a clear clinical rationale.</p> <p>Please Note: Beacon will <i>not</i> authorize periodic testing to measure the member's response to psychotherapy.</p>
--	--	---

<ol style="list-style-type: none"> 2) Testing is primarily for legal purposes, unless specified by state regulations or account-specific arrangements. 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). 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. 6) Measures proposed have no standardized norms or documented validity. 7) The time requested for a test/test battery falls outside Beacon Health Options established time parameters. 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. 9) Symptoms of acute psychosis, confusion, disorientation, etc., interfering with proposed testing validity are present. 10) Administration, scoring and/or reporting of projective testing is performed by someone other than a licensed psychologist, or other clinician for whom psychological testing falls within the scope of their clinical licensure and who has specialized training in psychological testing. 		
---	--	--

E. NMNC 5.503.01 Biofeedback

Biofeedback is a process that enables an individual to learn how to change physiological activity for the purpose of improving health and performance. Precise instruments measure physiological activity such as brainwaves, heart function, breathing, muscle activity and skin temperature. These instruments rapidly and accurately “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. (Association for Applied Psychophysiology and Biofeedback, 2008).

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 mixed services protocol defining coverage of specific services.
- Biofeedback is typically performed in the outpatient office setting and is usually not used 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 benefit. If Biofeedback is not covered, an administrative determination of non-coverage will be rendered. The current determination by Beacon Health Options is that Biofeedback does not currently meet the criteria for inclusion as an evidence-based treatment for behavioral health disorders. The treatment of Anxiety Disorders, however, has the most supporting evidence for the treatment of behavioral health disorders. Application of these 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).

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 1) Biofeedback is a listed covered benefit with no specific included diagnoses and is being requested for the treatment of an Anxiety Disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and can be reasonably expected to respond to this treatment modality as a component of a comprehensive treatment plan. 2) Biofeedback is a covered benefit with specific included diagnoses and the request for services is for a covered diagnosis listed in the most recent DSM; and can be reasonably expected to respond to this treatment modality as a component of a comprehensive treatment plan. 3) There are significant symptoms that interfere with the individual's ability to function in at least one life area. <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1) Biofeedback is being requested for a physical health condition (request should be directed to medical plan). 2) The individual has conditions or impairments that would prevent beneficial utilization of Biofeedback. 3) Biofeedback is being requested for any behavioral health diagnosis except one specifically listed as a benefit or an Anxiety Disorder in the absence of 	<p>All of the following criteria must be met:</p> <ol style="list-style-type: none"> 1) The individual continues to meet admission criteria for Biofeedback. 2) The individual does not require a more intensive level of care or service, and no less intensive services are appropriate. 3) The frequency of sessions is occurring or scheduled to occur at a rate that is appropriate to the individual's current symptoms, and no less frequency of sessions would be sufficient to meet their needs. 4) Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. 5) All services and treatment are carefully structured to achieve optimum results in the most efficient manner possible, consistent with sound clinical practice. Expected benefit from the Biofeedback is documented. 6) Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident. or 7) Continued Biofeedback is expected to prevent the need for more intensive services or levels of care. 	<p>Any one of the following: Criteria 1, 2, 3, 4, 5, or 6:</p> <ol style="list-style-type: none"> 1) The individual's documented treatment plan goals and objectives have been substantially met. 2) The individual no longer meets admission criteria, or meets criteria for a less or more intensive service or level of care. 3) The individual is competent and non-participatory in treatment, or the individual's non-participation is of such degree that treatment is rendered ineffective, or unsafe despite multiple, documented attempts to address non-participation issues. 4) Consent for treatment is withdrawn and it is determined that the individual has the capacity to make an informed decision. 5) The individual is not making progress toward treatment goals, and there is no reasonable expectation of progress

<p>specifically covered diagnoses listed in the most recent version of the DSM.</p> <p>4) Biofeedback is not being used as an adjunctive treatment in a comprehensive treatment regimen.</p> <p>5) Standard accepted outpatient treatments (including psychotherapy and medication management) are sufficient to safely and effectively treat the individual.</p>	<p>8) Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan.</p> <p>9) When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated in a timely manner.</p> <p>10) There is documented active discharge planning from the beginning of treatment, which includes ensuring the ability of the individual to continue the Biofeedback learned techniques independently after discharge.</p>	<p>with this treatment approach.</p> <p>6) It is reasonably predicted that continuing stabilization can occur with discontinuing Biofeedback with ongoing medication management and/or psychotherapy and community support.</p>
---	--	---

SECTION V: OTHER SPECIAL BEHAVIORAL HEALTH SERVICES

Overview

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

- A. **NMNC 6.601.0 Electro-Convulsive Therapy**
- B. **Personalized Recovery Orientated Services (PROS)**
- C. **Assertive Community Treatment (ACT)**
- D. **NMNC 6.602.0 Repetitive Transcranial Magnetic Stimulation**
- E. **Home and Community Based Services (Use of this level of care is specific to a Health Plan's authorization requirements)**

A. NMNC 6.601.0 Electro-Convulsive Therapy

Electro-Convulsive (ECT) Therapy is a procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity while the member is under 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.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1-5 must be met:</p> <ul style="list-style-type: none"> 1) DSM or corresponding ICD diagnosis of major depression, schizophrenia, schizoaffective mood disorder, or other disorder with features that include mania, psychosis, and/or catatonia; 2) Member has been medically cleared and there are no contraindications to ECT (i.e. Intracranial or cardiovascular, or pulmonary contraindications); 3) There is an immediate need for rapid, definitive response due to at least one of the following: 4) Significant risk of harm to self or others; 5) catatonia 6) Intractable manic episode 	<p>All of the following criteria 1-8 must be met:</p> <ul style="list-style-type: none"> 1) The member continues to meet admission criteria; 2) An alternative treatment would not be more appropriate to address the members ongoing symptoms; 3) The member is in agreement to continue treatment of ECT; 4) Treatment is still necessary to reduce symptoms and improve functioning; 	<p>Any one of the following: Criteria 1, 2, 3, 4, or 5:</p> <ul style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive. 2) Member withdraws consent for treatment or refuses treatment and does not meet criteria for involuntary mandated treatment.

<p>7) Other treatments could potentially harm the member due to slower onset of action.</p> <p>8) The benefits of ECT outweigh the risks of other treatments as evidenced by at least one of the following:</p> <ul style="list-style-type: none"> a) Member has not responded to adequate medication trials; b) Member has had a history of positive response to ECT. <p>9) Maintenance ECT, as indicated by all of the following:</p> <ul style="list-style-type: none"> a) Without maintenance ECT member is at risk relapse b) Adjunct therapy to pharmacotherapy c) Sessions tapered to lowest frequency that maintains baseline <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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; 	<ul style="list-style-type: none"> 5) There is evidence of subjective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress; 6) The total number of treatments administered is proportional to the severity of symptoms, rate of clinical improvement, and adverse side effects; 7) There is documented coordination with family and community supports as clinically appropriate; 8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 	<ul style="list-style-type: none"> 3) Member is not making progress toward goals, nor is there expectation of any progress. 4) Member's individual treatment plan and goals have been met. 5) Member's natural support (or other support) systems are in agreement with following through with member care, and the member is able to be in a less restrictive environment.
---	--	--

<ul style="list-style-type: none"> c) increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions; d) recent cerebral infarction; e) pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia; and, f) anesthetic risk rated as American Society of Anesthesiologists level 4 or 5. 		
--	--	--

B. Personalized Recovery Orientated Services (PROS)

PROS programs offer a customized array of recovery-oriented services, both in traditional program settings and in off-site locations where people live, learn, work or socialize. The purpose of PROS is to assist individuals in recovering from the disabling effects of mental illness through the coordinated delivery of rehabilitation, treatment and support services. Goals for members in the program 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.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
--------------------	-------------------------	--------------------

<p>All of the following criteria 1 – 10 must be met:</p> <ol style="list-style-type: none"> 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. 	<p>All of the following criteria 1 – 3 must be met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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. 	<p>Any one of the following: Criteria 1, 2, 3, or 4:</p> <ol style="list-style-type: none"> 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

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>Any one of the following: Criteria 1, 2, 3, or 4:</p> <ol style="list-style-type: none"> 1) Member has a specific goal related to competitive employment. 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. 3) Member would benefit from support in managing their symptoms in a competitive workplace. 4) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services. 	<p>Any one of the following: Criteria 1, 2, 3, or 4:</p> <ol style="list-style-type: none"> 1) Member continues to have a goal for competitive employment. 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. 3) Member continues to benefit from supportive services in managing their symptoms in the competitive workplace. 4) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services. 	<p>Any one of the following: Criteria 1, 2, or 3:</p> <ol style="list-style-type: none"> 1) The member no longer requires supportive services for managing symptoms in the competitive workplace. 2) The member no longer is seeking competitive employment. 3) The member has achieved current recovery goals and can identify no other goals that would require ongoing rehabilitation and support.

Intensive Rehabilitation (IR) Criteria

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>Any one of the following: Criteria 1, 2, 3, 4, or 5:</p> <ol style="list-style-type: none"> 1) Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe. 2) The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention. 3) Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure. 4) Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Treatment for Dual Disorders. 5) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services. 	<p>Any one of the following: Criteria 1, 2, 3, 4, or 5:</p> <ol style="list-style-type: none"> 1) Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe. 2) The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention. 3) Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure. 4) Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Treatment for Dual Disorders. 5) A member is not receiving Home and Community Services other than peer support services, 	<p>Any one of the following: Criteria 1, 2, or 3:</p> <ol style="list-style-type: none"> 1) The member is no longer at risk of hospitalization, involvement in criminal justice system and community tenure is assured in which intensive rehabilitation is no longer required. 2) The member has achieved current recovery goals and can identify no other goals that would require intensive rehabilitation. 3) The member can live, learn, work and socialize in the community with supports from natural and/or community resources without intensive rehabilitation.

	education support services and crisis residential services.	
--	---	--

C. Assertive Community Treatment (ACT)

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

Initial Authorization Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1 - 5 must be met; Criteria 6 & 7 may also be met:</p> <ol style="list-style-type: none"> 1) Severe and persistent mental illness (including, but, not limited to diagnoses of schizophrenia, schizoaffective disorder, bipolar disorder and/or major or chronic depression), that seriously impairs their functioning in the community. 2) Recipients with serious functional impairments should demonstrate at least one of the following conditions: 	<ol style="list-style-type: none"> 1) Initial authorization criteria continue to be met. 2) A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals. Service plan is reviewed for progress and updated every 6 months, as necessary. Continued coordination of care with other providers/stakeholders 	<p>Any one of the following: Criteria 1, 2, 3, or 4; Criteria 5 & 6 are recommended, but optional:</p> <p>ACT recipients meeting any of the following criteria may be discharged:</p> <ol style="list-style-type: none"> 1) Individuals who demonstrate, over a period of time, an ability to function

<ul style="list-style-type: none"> 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). <p>3) Recipients with continuous high service needs should demonstrate one or more of the following conditions:</p> <ul style="list-style-type: none"> 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. <p>4) Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision.</p>	<ul style="list-style-type: none"> 3) such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc. Active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC, when appropriate. 4) 	<p>in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service.</p> <ul style="list-style-type: none"> 2) Individuals who move outside the geographic area of the ACT team's responsibility, subsequent to the transfer of care to another ACT team or other appropriate provider and continued services until the member is engaged in care. 3) Individuals who need a medical nursing home placement, as determined by a physician. 4) Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail. 5) Individuals who request discharge, 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
---	--	--

<p>5) Member's condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions.</p> <p>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.</p> <p>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.</p> <p>Exclusions</p> <p><i>The following criteria is required for exclusion from this level of care:</i></p> <p>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.</p>		<p>history of suicide, assault or forensic involvement.</p> <p>6) Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons", including, but, not limited to, conferring with Health Homes and MMCO/HARPs, to which Member may be assigned.</p>
---	--	---

D. NMNC 6.602.0 Repetitive Transcranial Magnetic Stimulation

Description of Services: Repetitive Transcranial Magnetic Stimulation (rTMS) is a noninvasive method of brain stimulation. In rTMS, an electromagnetic coil is positioned against the individual's scalp near his or her forehead. A Magnetic Resonance Imaging (MRI)-strength, pulsed, magnetic fields then induce an electric current in a localized region of the cerebral cortex, which induces a focal current in the brain and temporary modulation of cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Depending on stimulation parameters, repetitive TMS to specific cortical regions can either decrease or increase the excitability of the targeted structures. rTMS 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 shown 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 and with treatment adherence. rTMS is usually administered four to six times per week and for six weeks or less. It is typically performed in an outpatient office. rTMS is not considered proven for maintenance treatment. The decision to recommend the use of rTMS derives from

a risk/benefit analysis for the specific member. This analysis considers the diagnosis of the member and the severity of the presenting illness, the member's treatment history, any potential risks, anticipated adverse side effects and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
<p>All of the following criteria 1 – 9 must be met:</p> <ol style="list-style-type: none"> 1) The member must be at least 18 years of age. 2) The individual demonstrates behavioral symptoms consistent with unipolar Major Depression Disorder (MDD), severe degree without psychotic features, either single episode, or recurrent, as described in the most current version of the DSM, or corresponding ICD, and must carry this diagnosis. 3) Depression is severe as defined and documented by a validated, self-administered, evidence-based monitoring tool (i.e. QID- SR16, PHQ-9, HAM-D or BDI, etc.). 4) The diagnosis of MDD cannot be made in the context of current or past history of manic, mixed or hypomanic episode. 5) The member has no active (within the past year) substance use or eating disorders. 6) Member must exhibit treatment-resistant depression in the current treatment episode with all of the following: <ol style="list-style-type: none"> a) Lack of clinically significant response (less than 50% of depressive symptoms) b) Documented symptoms on a valid, evidence-based monitoring tool; c) Medication adherence and lack of response to at least 2 psychopharmacologic trials in the current episode of treatment at the minimum dose and from 2 different medication classes; 7) Member must not meet any of the exclusionary criteria below; 8) rTMS is administered by a US Food and Drug 	<p>All of the following criteria 1 – 8 must be met:</p> <ol style="list-style-type: none"> 1) The member continues to meet admission criteria; 2) An alternative treatment would not be more appropriate to address the members ongoing symptoms; 3) The member is in agreement to continue TMS treatment and has been adherent with treatment plan; 4) Treatment is still necessary to reduce symptoms and improve functioning; 5) There is evidence of objective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress; 6) 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; 7) There is documented coordination with family and community supports as appropriate; 8) Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 	<p>Any one of the following: Criteria 1, 2, 3, 4, or 5:</p> <ol style="list-style-type: none"> 1) The individual has achieved adequate stabilization of the depressive symptoms 2) Member withdraws consent for treatment 3) Member no longer meets authorization criteria and/or meets criteria for another level of care, either more or less intensive. 4) The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement (e.g. validated rating scale and behavioral description) and there is no reasonable expectation of progress. 5) Worsening of depressive symptoms such as increased suicidal thoughts/behaviors or unusual behaviors.

<p>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.</p> <p>9) The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy and directly supervises the procedure (on site and immediately available).</p> <p>The following criteria may apply:</p> <p>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., Geriatric Depression Scale (GDS), Personal Health Questionnaire Depression Scale (PHQ-9), Beck Depression Scale (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory for Depressive Symptomatology Systems Review (IDS-SR) and now has a relapse after remission and meets all other authorization criteria.</p> <p>Exclusions</p> <p><i>Any of the following criteria are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1) The individual has medical conditions or impairments that would prevent beneficial utilization of services. 2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. The safety and effectiveness of rTMS has not been established in the following member populations 		
--	--	--

<p>or clinical conditions through a controlled clinical trial, therefore the following are exclusion criteria.</p> <ol style="list-style-type: none"> 3) Members who have a suicide plan or have recently attempted suicide. 4) Members who do not meet current DSM or corresponding ICD criteria for major depressive disorder. 5) Members younger than 18 years of age or older than 70 years of age. 6) Members with history recent history of active of substance abuse, obsessive compulsive disorder or post-traumatic stress disorder. 7) Members with a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features. 8) Members with neurological conditions that include epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS. 9) The presence of vagus nerve stimulator leads in the carotid sheath. 10) The presence of metal or conductive device in their head or body that is contraindicated with rTMS. For example, metals that are within 30cm of the magnetic coil and include, but are not limited to, cochlear implant, metal aneurysm coil or clips, bullet fragments, pacemakers, ocular implants, facial tattoos with metallic ink, implanted cardioverter defibrillator, metal plates, vagus nerve stimulator, deep brain stimulation devices and stents. 11) Members with Vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators. <p>rTMS is not indicated for maintenance treatment. There is insufficient evidence to support the efficacy of</p>		
---	--	--

<p>maintenance therapy with rTMS. rTMS for maintenance treatment of major depressive disorder is experimental / investigational due to the lack of demonstrated efficacy in the published peer reviewed literature.</p>		
---	--	--

E. Home and Community Based Services –

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: <https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/>). This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals and preferences, and also ensures member choice of service options and providers.

Criteria for HCBS services 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 resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

b) **Community Psychiatric Support and Treatment (CPST):**

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

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

a) **Pre-vocational Services:**

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

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

b) Transitional Employment (TE):

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

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

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

c) Intensive Supported Employment (ISE):

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

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

d) Ongoing Supported Employment:

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum

wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

3) 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.

Admission Criteria:	Continued Stay Criteria:	Discharge Criteria:
<p>All of the following criteria 1 – 7 must be met:</p> <ol style="list-style-type: none"> 1) The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool. 2) Where the member has been deemed eligible to receive services, a 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. 3) Upon receipt of notification from the HCBS provider(s), up to 3 visits over 14 days is authorized for intake and evaluation. 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. 5) The service request must support the member’s efforts to manage their condition(s) while 	<p>All of the following criteria 1 – 5 must be met:</p> <ol style="list-style-type: none"> 1) Member continues to meet admission criteria and an alternative service would not better serve the member. 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. 3) One of the following is present: <ol style="list-style-type: none"> a) Member is making measureable progress towards a set of clearly defined goals; Or b) There is evidence that the service plan is modified to address the barriers in treatment progression; Or c) Continuation of services is necessary to maintain progress already 	<p>Any one of the following: Criteria 1, 2, 3, 4, or 5; criteria #6 is recommended, but optional:</p> <ol style="list-style-type: none"> 1) Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive. 2) Member or parent/guardian withdraws consent for treatment. 3) Member does not appear to be participating. 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

<p>establishing a purposeful life and sense of membership in a broader community.</p> <p>6) The member must be willing to receive home and community based services.</p> <p>7) There is no alternative level of care or co-occurring service that would better address the member's clinical needs.</p>	<p>achieved and/or prevent deterioration.</p> <p>4) There is care coordination with physical and behavioral health providers, State, and other community agencies.</p> <p>5) Family/guardian/caregiver is participating in treatment where appropriate.</p> <p>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.</p>	<p>in collaboration with the member, the member's family members (if applicable), Health Home, HCBS provider, and MCO.</p> <p>5) Member's goals have been met.</p> <p>6) Member's support system is in agreement with the aftercare service plan.</p>
---	--	---