



Magellan Complete Care 2020 Magellan Care Guidelines

Approved by Utilization Management Committee (UMC): 6/23/20
Approved by Quality Improvement Committee (QIC): 6/30/20

Table of Contents

| | |
|--|----|
| Preamble - Principles of Medical Necessity Determinations | 4 |
| Medical Necessity Definition | 6 |
| Levels of Care & Service Definitions..... | 8 |
| Magellan Care Guidelines..... | 11 |
| Magellan Complete Care Behavioral Health Care Guidelines..... | 13 |
| Statewide Inpatient Psychiatric Program | 13 |
| Psychological Testing | 20 |
| Neuropsychological Testing | 23 |
| Community Behavioral Health Services..... | 30 |
| a. Clubhouse Services – Adult (H2030)..... | 30 |
| b. Therapeutic Behavioral On-Site Services - Child and Adolescent (H2019 HO, H2019 HM, H2019 HN) | 32 |
| Behavioral Health Overlay Service (BHOS- H2020 HA) | 34 |
| Therapeutic Group Care Services (H0019)..... | 37 |
| Specialized Therapeutic Foster Care Services | 40 |
| Exclusions for Community Behavioral Health Services, Behavioral Health Overlay Services and Specialized Therapeutic Services | 44 |
| Mental Health Targeted Case Management..... | 44 |
| a. Adult (T1017)..... | 44 |
| b. Child and Adolescent (T1017 HA) | 46 |
| c. Intensive Case Management (T1017 HK) | 48 |
| d. Mental Health Targeted Case Management Restrictions | 50 |

Preamble - Principles of Medical Necessity Determinations

Magellan Complete Care uses MCG *Guidelines*®, along with its proprietary clinical criteria, Magellan Healthcare Guidelines, as the primary decision support tools for our Utilization Management Program. Collectively, they are known as the *Magellan Care Guidelines*. Magellan uses other State mandated criteria where required.

All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services.

Individualized, Needs-Based, Least-Restrictive Treatment

Magellan Complete Care is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual enrollee's biopsychosocial needs. Magellan Complete Care sees the continuum of care as a fluid treatment pathway, where enrollees may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active and takes into consideration the enrollee's stage of readiness to change/readiness to participate in treatment.

The levels of care criteria that follow are guidelines for determining medical necessity for conditions defined in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5™). Individuals may at times seek admission to clinical services for reasons other than medical necessity, e.g., to comply with a court order, to obtain shelter, to deter antisocial behavior to deter runaway/truant behavior, to achieve family respite, etc. However, these factors do not alone determine a medical necessity decision. Further, coverage for services is subject to the limitations and conditions of the member benefit plan. Specific information in the member's contract and the benefit design for the plan dictate which medical necessity criteria are applicable.

Although these Magellan Care Guidelines are divided into "psychiatric" and "substance-related" sets to address the enrollee's primary problem requiring each level of care, psychiatric and substance-related disorders are often co-morbid. Thus, it is very important for all treatment facilities and providers to be able to assess these co-morbidities and address them along with the primary problem.

Clinical Judgment and Exceptions

The Magellan Care Guidelines direct both providers and reviewers to the most appropriate level of care for an enrollee. While these criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. As in the review of

non-exceptional cases, clinical judgment consistent with the standards of good medical practice will be used to resolve these exceptional cases.

All medical necessity decisions about proposed admission and/or treatment, other than outpatient, are made by the reviewer after receiving a sufficient description of the current clinical features of the enrollee's condition that have been gathered from a face-to-face evaluation of the enrollee by a qualified clinician. Medical necessity decisions about each enrollee are based on the clinical features of the individual enrollee relative to the enrollee's socio-cultural environment, the medical necessity criteria, and the real resources available. Magellan Complete Care recognizes that a full array of services is not available everywhere. When a medically necessary level does not exist (e.g., rural locations), Magellan Complete Care will support the enrollee through extra-contractual benefits, or will authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the enrollee's essential needs for safe and effective treatment.

Exceptions to the Limits (Special Services)

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage limits described in AHCA's policy or the associated fee schedule may be approved, if medically necessary.

Mental Health Parity

It is the policy of Magellan Complete Care to be in full compliance with the 42 CFR 438, subpart K regarding the Mental Health Parity and Addictions Equity Act (MHPAEA) and 42 CFR 438.910(d).

Magellan Complete Care complies with the Florida Medicaid Coverage policies and fee schedules. Magellan Complete Care does not apply any financial requirement or treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all med/surg benefits in the same classification. Magellan Complete Care does not impose more restrictive nonquantitative treatment limitation for MH/SUD benefits in any classification unless, under the policies and procedures of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for med/surg benefits in the classification. Magellan Complete Care uses the coverage policies along with nationally accepted clinical criteria as a guide to managing care. Magellan Complete Care can and does exceed the coverage policy provisions when medical necessity is met based on enrollee need and level of functioning. Services in excess of the State benefit limits will be reviewed for medical necessity.

Medical Necessity Definition

Magellan reviews mental health and substance use treatment for medical necessity. Magellan defines medical necessity as:

In accordance with 59G-1.010 Florida Administrative Code, medically necessary means:

“The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

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

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

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

Magellan reviews mental health and substance use treatment for medical necessity.

Magellan defines medical necessity as: “Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:

1. consistent with:
 - a. the diagnosis and treatment of a condition; and
 - b. the standards of good medical practice;
2. required for other than convenience; and
3. the most appropriate supply or level of service.

When applied to inpatient care, the term means: the needed care can only be safely given on an inpatient basis.”

** Magellan utilizes its customers’ definition of “medical necessity” as required.*

Each criterion set, within each level of care category (see below) is a more detailed elaboration of the above definition for the purposes of establishing medical necessity for these health care services. Each set is characterized by admission and continued stay criteria. The admission criteria are further delineated by severity of need and intensity and quality of service.

Particular rules in each criterion set apply in guiding a provider or reviewer to a medically necessary level of care (please note the possibility and consideration of exceptional enrollee situations described in the preamble when these rules may not apply). For admission, both the severity of need and the intensity and quality of service criteria must be met. The continued stay of a enrollee at a particular level of care requires the continued stay criteria to be met (Note: this often requires that the admission criteria are still fulfilled). Specific rules for the admission and continued stay groupings are noted within the criteria sets.

Magellan Care Guidelines do not supersede state or Federal law or regulation, including Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

Levels of Care & Service Definitions

Magellan Complete Care believes that optimal, high-quality care is best delivered when enrollees receive care that meets their needs in the least-intensive, least-restrictive setting possible. Magellan's philosophy is to endorse care that is safe and effective, and that maximizes the enrollee's independence in daily activity and functioning.

Magellan Complete Care of Florida has defined levels of care as detailed below. These levels of care may be further qualified by the distinct needs of certain populations who frequently require behavioral health services. Children, adolescents, geriatric adults and those with substance use and eating disorders often have special concerns not present in adults with mental health disorders alone. In particular, special issues related to family/support system involvement, physical symptoms, medical conditions and social supports may apply. More specific criteria sets in certain of the level of care definitions address these population issues. These levels of care are specific to Magellan Complete Care of Florida and may not all apply to all Magellan accounts. The eight levels of care definitions are:

1. Hospitalization

- a. Hospitalization describes the highest level of skilled psychiatric and substance use services provided in a facility. This could be a freestanding psychiatric hospital, a psychiatric unit of general hospital or a detoxification unit in a hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.
- b. This definition also includes crisis beds, hospital-level rehabilitation beds for substance use disorders and 23-hour beds that provide a similar, if not greater, intensity of medical and nursing care. For crisis and 23-hour programs, the psychiatric hospitalization criteria apply for medical necessity reviews. For hospital-level substance use rehabilitation, the Hospitalization, Rehabilitation Treatment, Substance Use Disorder criteria set applies. For subacute hospitalization, the Hospitalization, Subacute criteria set applies.

2. Observation

- a. The main objective of observation is to promptly evaluate and stabilize individuals presenting in a crisis situation. This level of care provides up to 48 hours of observation and crisis stabilization, as needed. Care occurs in a secure and protected environment staffed with appropriate medical and clinical personnel, including psychiatric supervision and 24-hour nursing coverage.
- b. Aspects of care include a comprehensive assessment and the development and delivery of a treatment plan. The treatment plan should emphasize crisis intervention services intended to stabilize and restore the individual to a level of functioning that does not necessitate hospitalization. In addition, 48-hour observation may be used to complete an evaluation to determine diagnostic clarification to establish the appropriate level of care. As soon as the risk level is determined, diagnostic clarity is established, and/or crisis stabilization has been achieved, appropriate referral and linkage to follow-up services will occur.

- c. If clinical history or initial presentation suggested that the individual required a secure and protected inpatient level of care for more than 48 hours a, this level of care would not be appropriate.

3. Residential Treatment

Residential Treatment is defined as a 24-hour level of care that provides persons with long-term or severe mental disorders and persons with substance-related disorders with residential care. This care is medically monitored, with 24-hour medical and nursing services availability. Residential care typically provides less intensive medical monitoring than subacute hospitalization care. Residential care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each enrollee. Residential treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance use are included in this level of care. Licensure requirements for this level of care are specific by State.

4. Partial Hospitalization

These programs are defined as structured and medically supervised day, evening and/or night treatment programs. The services include medical and nursing, but at less intensity than that provided in a hospital setting. The enrollee is not considered a resident at the program. The range of services offered is designed to address a mental health and/or substance-related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

5. Intensive Outpatient Programs

Intensive outpatient programs are defined as having the capacity for planned, structured, service provision over the course of multiple weeks, and may include service provision over weekends. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment.” (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge).

6. Outpatient Treatment

Outpatient treatment is typically individual, family and/or group psychotherapy, and consultative services (including nursing home consultation). Times for provision of these service episodes range from fifteen minutes (e.g., medication checks) to fifty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

7. Ambulatory

Ambulatory services are outpatient treatment services, provided by qualified mental health professionals and directed toward reversing symptoms of acute mental health disorders, and/or substance use disorders in order to facilitate improvement, maintain stability and increase functional autonomy for persons with various forms of mental health and substance use disorders. Outpatient services are specific in targeting the symptoms or problem being treated. Examples of types of Counseling and Psychotherapy include the following:

- a. individual psychotherapy
- b. behavioral therapy
- c. medication management
- d. shared medical appointments
- e. psychiatric, psychological, and psychosocial assessment
- f. group psychotherapy
- g. conjoint/marital therapy
- h. family therapy.
- i. outpatient detox services
- j. outpatient buprenorphine maintenance services

Common settings or sites for these services include providers' offices and clinics.

8. Day Treatment

Day treatment consists of a community-based mix of psychosocial treatment (including individual, family, and group-based psychotherapy), educational, and recreational activities for enrollees with behavioral health conditions associated with functional impairment (e.g., inability to maintain full-time engagement in work, school, or home environment as appropriate). Day treatment is designed to address issues that are chronic in nature, rather than acute exacerbations or urgent clinical issues; services tend to overlap with regular school or work schedules, and typically are of longer duration than intensive outpatient or partial hospital programs (e.g., an adolescent in day treatment may be enrolled in a program which lasts for the entire school year. While enrollees for whom day treatment is indicated do not require the intensity of services available in an intensive outpatient or partial hospital program, some day treatment programs provide diagnostic, medical, psychiatric, or other adjunctive treatment modalities, either directly or through arrangements made by the program. These services may be provided over an extended period of time.

Magellan Care Guidelines

MCG *Guidelines*® are utilized by Magellan and to view a copy of MCG *Guidelines*®, please contact us at 800-327-8613.

MCG *Guidelines*®

- Inpatient Behavioral Health Level of Care, Adult
- Inpatient Behavioral Health Level of Care, Child or Adolescent
- Residential Behavioral Health Level of Care, Adult
- Residential Behavioral Health Level of Care, Child or Adolescent
- Partial Hospital Behavioral Health Level of Care, Adult
- Partial Hospital Behavioral Health Level of Care, Child or Adolescent
- Intensive Outpatient Program Behavioral Health Level of Care, Adult
- Intensive Outpatient Program Behavioral Health Level of Care, Child or Adolescent
- Acute Outpatient Behavioral Health Level of Care, Adult
- Acute Outpatient Behavioral Health Level of Care, Child or Adolescent
- Substance-Related Disorders, Inpatient Behavioral Health Level of Care, Adult
- Substance-Related Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent
- Substance-Related Disorders, Residential Behavioral Health Level of Care, Adult
- Substance-Related Disorders, Residential Behavioral Health Level of Care, Child or Adolescent
- Substance-Related Disorders, Partial Hospital Behavioral Health Level of Care, Adult
- Substance-Related Disorders, Partial Hospital Behavioral Health Level of Care, Child or Adolescent
- Substance-Related Disorders, Intensive Outpatient Program Behavioral Health Level of Care, Adult
- Substance-Related Disorders, Intensive Outpatient Program Behavioral Health Level of Care, Child or Adolescent
- Substance-Related Disorders, Acute Outpatient Behavioral Health Level of Care, Adult
- Substance-Related Disorders, Acute Outpatient Behavioral Health Level of Care, Child or Adolescent
- Medication-Assisted Opioid Withdrawal
- Outpatient Opioid Maintenance Treatment
- Observation Behavioral Health Level of Care, Adult
- Electroconvulsive Therapy (ECT)
- Psychosocial Rehabilitation
- Day Treatment Behavioral Health Level of Care

Magellan Complete Care Behavioral Health Care Guidelines

To view a copy of the Magellan Complete Care-Behavioral Health Care Guidelines, visit www.magellancompletecareoffl.com

Magellan Complete Care Behavioral Health Care Guidelines for 2020

- Statewide Inpatient Psychiatric Program (SIPP)
- Behavioral Health Assessment Services:
 - Psychological Testing
 - Neuropsychological Testing
- Behavioral Health Community Support Services:
 - Clubhouse Services- Adult
- Behavioral Health Intervention Services
 - Therapeutic Behavioral On-Site Services- Child and Adolescent
- Behavioral Health Overlay Services
- Therapeutic Group Care Services
- Specialized Therapeutic Foster Care Services
- Mental Health Targeted Case Management- Adult, Child and Adolescent, Intensive

Magellan Complete Care Behavioral Health Care Guidelines

Statewide Inpatient Psychiatric Program

Service Description:

Florida Medicaid's Statewide Inpatient Psychiatric Program (SIPP) services provide extended residential psychiatric treatment, with the goal of facilitating successful return to treatment in a community-based setting.

Admission Criteria

(Must meet all criteria: 1, 2, 3, 4, and 5):

1. Is under age of 21 years with emotional disturbance or serious emotional disturbance otherwise defined in Chapter 394, F.S. AND require treatment in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance
2. Pre-admission assessment requirement met:
Recipients in the care and custody of the state must be assessed in accordance with section 39.407(6)(b), F.S.
Or
Recipients not in the care and custody of the state must be assessed by a Florida-licensed psychologist or psychiatrist, with experience or training in childhood disorders. The assessment must result in a report with written findings as required by the Department of Children and Families in Rule 65E-9.008, F.A.C.
3. Medical clearance given by a physician prior to admission.
4. The child or adolescent has age appropriate cognitive and developmental ability to benefit from cognitive-based treatment and group setting.
5. CFR 441.152 Federal requirements A, B, and C shall be met for admission to a SIPP.
 - a. Ambulatory care resources available in the community do not meet the treatment needs of the enrollee (42 CFR 441.152(a)). A reasonable course of acute inpatient treatment and/or intensive outpatient services has failed to bring about adequate resolution of significant symptoms to permit placement in a less restrictive setting in the community.

To meet this requirement, one of the following shall be established:

- i. A lower level of care will not meet the enrollee's treatment needs.
Examples of lower levels of care include
 - Family or relative placement with outpatient therapy;
 - Day or after-school treatment;

- Foster care with outpatient therapy;
 - Therapeutic foster care;
 - Group childcare supported by outpatient therapy;
 - Therapeutic group childcare;
 - Partial hospitalization; and
 - Custodial care.
- ii. An appropriate lower level of care is unavailable or inaccessible and a reasonable course of acute inpatient treatment has failed to resolve significant symptoms to permit a safe return to the community.
- b. Proper treatment of the enrollee’s psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement, all of the following criteria must be met:

- i. An ICD10 diagnoses is present and has been established through a documented comprehensive bio-psychosocial diagnostic assessment. The diagnosis must indicate the presence of a psychiatric disorder that is severe in nature and requires more intensive treatment than can be provided on an outpatient basis. As an example, the following diagnoses may indicate the need for SIPP care when acute inpatient treatment has not adequately resolved significant symptoms and behaviors: Major Depressive Disorder, active Post Traumatic Stress Syndrome with continued fragility, and newly diagnosed psychotic disorders. A concurrent substance use disorder may be present.
- ii. The enrollee is currently experiencing problems related to the mental disorder diagnosed in one of the following categories designated below:
- a. Self-care Deficit (not Age Related): Basic impairment of needs or nutrition, sleep, hygiene, rest, or stimulation related to the enrollee’s mental disorder and severe and long-standing enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications).

OR

- b. Impaired Safety (Threat to Self or Others): Evidence of intent to harm self or others caused by the enrollee’s mental disorder; and unable to function in community setting, provided that such intent does not constitute a clinically emergent situation. Threats to harm self or others accompanied by one of the following:
- Severely depressed mood
 - Recent loss
 - Recent suicide attempt or gesture or past history of multiple attempts or gestures
 - Concomitant substance use
 - Recent suicide or history of multiple suicides in family or peer group

OR

- c. Impaired Thought and/or Perceptual Processes (Reality Testing): Inability to perceive and validate reality to the extent that the enrollee cannot negotiate his/her basic environment, nor participate in family or school (e.g., paranoia, hallucinations, delusions) and it is likely that the enrollee will suffer serious harm.

Indicators:

- Disruption of safety of self, family, peer, or community group
- Impaired reality testing sufficient to prohibit participation in any community educational alternative
- Not responsive to outpatient trial of medication or supportive care
- Requires sub-acute diagnostic evaluation to determine treatment needs

OR

- d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes that place the enrollee at risk

Indicators (one of the following):

- Family environment is causing escalation of enrollee's symptoms or places enrollee at risk.
- The family situation is not responsive to available outpatient or community resources and intervention.
- Instability or disruption is escalating.
- The situation does not improve with the provision of economic or social resources.
- Severe behavior or established pattern of behavior prohibits any participation in a lower level of care (e.g., habitual runaway, prostitution, repeated substance use).

- iii. The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care, etc.) as evidenced by documented presence of
- a. Deficits in cognition, control, or judgment due to diagnosis (es);
 - b. Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance; and
 - c. Prognostic indicators that predict the effectiveness of treatment.
- iv. The facility requesting prior authorization describes a proposed plan of active treatment based on comprehensive assessment that addresses medical, psychiatric, neurological, psychological, social, educational, and substance use needs, specifically
- a. Services shall be under the supervision of a physician advisor;
 - b. Intervention of qualified professionals shall be available 24 hours a day; and

- c. Multiple therapies (e.g., group counseling, individual counseling, pre-vocational therapy, family therapy, recreational therapy, expressive therapies, etc.) shall be actively provided to the enrollee. Families or surrogates must be involved in the treatment. Family therapy with families or surrogates must be included unless clinically contraindicated, with an expectation of at least one family session per week.
- c. The services can reasonably be expected to improve the enrollee's condition within a reasonable timeframe of three to six months or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).
 - i. The treating facility shall provide a description of the plan for treatment illustrating the required services available at a SIPP level of care.
 - ii. The treating SIPP facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, measurable, and time-framed discharge criteria.
 - iii. The benefits of SIPP care are expected to result in maintaining or improving the enrollee's level of functioning.

Continued Stay Criteria:

(All of the following shall be met 1, 2 and 3):

1. Ambulatory care resources available in the community do not meet the treatment needs of the enrollee (42 CFR 441.152(a)).

To meet this requirement, one of the following shall be established:

- a. A lower level of care is unsafe and will place the enrollee in imminent danger of harm.

Examples of lower levels of care include

- Family or relative placement with outpatient therapy;
 - Day or after-school treatment;
 - Foster care with outpatient therapy;
 - Therapeutic foster care;
 - Group childcare supported by outpatient therapy;
 - Therapeutic group childcare;
 - Partial hospitalization; and
 - Custodial care.
- b. Clinical evidence exists that a lower level of care will not meet the enrollee's treatment needs.
 - c. The enrollee's mental disorder could be treated with a lower level of care, but because the enrollee suffers one or more complicating concurrent disorders, SIPP care is medically necessary.

Example: Major Depressive Disorder with Epilepsy

2. Proper treatment of the enrollee's psychiatric condition continues to require services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement, all of the following criteria must be met:

- a. The enrollee continues to have a psychiatric condition or disorder that is classified as an ICD 10 diagnosis. A concurrent substance use disorder may be present.
- b. The enrollee continues to experience problems related to the mental disorder diagnosed i in one of the following categories designated below:
 - i. Self-care Deficit (not Age Related): Impairment of ability to meet physical needs that place the enrollee at risk of self-harm.
Indicator:
 - (1) Self-care deficit severe and long-standing enough to make participation in an alternative setting in the community unsafe.
 - ii. Impaired Safety (Threat to Self or Others): Continued evidence of intent to harm self or others caused by the enrollee's mental disorder, provided that such intent does not constitute a clinically emergent situation.
Indicators:
 - (1) Continued suicidal/homicidal ideation with expression of plan of intent
 - (2) Potential for aggressive behavior requiring infrequent seclusion or restraint
 - iii. Impaired Thought and/or Perceptual Processes (Reality Testing): Inability to perceive and validate reality to the extent that the enrollee cannot negotiate his/her basic environment, nor participate in family or school (e.g., paranoia, hallucinations, and delusions), and it is likely that the enrollee will suffer serious harm.
Indicators:
 - (1) Disruption of safety of self, family, peer, or community group
 - (2) Impaired reality testing sufficient to prohibit participation in any community educational alternative
 - (3) Requires continued sub-acute diagnostic evaluation to determine treatment needs
 - iv. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes that place the enrollee at risk of serious harm
Indicators (one of the following):
 - (1) Family contacts and interaction and/or family environment are causing escalation of enrollee's symptoms and place the enrollee at risk of serious harm.
 - (2) Instability or disruption is escalating.
 - (3) Severe behavior prohibits any participation in a lower level of care (e.g., habitual runaway, prostitution, repeated substance use).
- c. The child or adolescent has a serious impairment of functioning compared with others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self care, etc.) as evidenced by documented presence of

- i. Deficits in cognition, control, or judgment due to diagnosis;
 - ii. Circumstances resulting from those deficits in self care, personal safety, social/family functioning, academic or occupational performance; and
 - iii. Prognostic indicators that predict the effectiveness of treatment.
 - d. The facility has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at this level of care, specifically:
 - i. Services shall be under the supervision of a physician advisor;
 - ii. Intervention of qualified professionals shall be available 24 hours a day; and
 - iii. Multiple therapies (group counseling, individual counseling, recreational therapy, expressive therapies, family therapy, etc.) shall be actively provided to the enrollee.
- 3. The services can reasonably be expected to improve the enrollee's condition or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).
 - a. The treating SIPP facility has developed a plan for continuing treatment illustrating the required intensity of services available at a SIPP level of care.
 - b. The treating SIPP facility has provided a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan was initiated as soon as the initial assessment was completed and included discrete, behavioral, and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.
 - c. There is evidence that discharge to available community resources will likely result in exacerbation of the mental disorder to the degree that continued SIPP hospitalization would be required or would result in regression.

Discharge Criteria:

The enrollee has received maximum benefit from his or her present plan of care

OR

The child has failed to benefit from a reasonable course of SIPP care, and documentation supports that a suitable alternative placement is established that will meet the child's needs, and the discharge plan includes input from family or surrogate family and DCF-Substance use and Mental Health program office

OR

Severe medical problems have arisen that cannot be managed by the SIPP facility. If it is determined that a child will require extensive medical attention, the SIPP may work with the Medicaid area office to disenroll the child from the SIPP, so that other Medicaid services can be accessed.

Exclusion Criteria

(Any of the following):

1. Less intensive levels of treatment will appropriately meet the needs of the child or adolescent.
2. The primary diagnosis is substance use, mental retardation, or autism.
3. The enrollee is not expected to benefit from this level of treatment.

4. The presenting problem is not psychiatric in nature and will not respond to psychiatric treatment.
5. The youth has a history of long-standing violations of the rights and property of others.
6. A pattern of socially directed disruptive behavior (e.g., gang involvement) is the primary presenting problem or remaining problem after any psychiatric issue has stabilized.
7. Enrollees cannot be admitted to a SIPP if they have Medicare coverage, reside in a nursing facility or ICF/DD, or have an eligibility period that is only retroactive or are eligible as medically needy.
8. Lack of medical clearance from a physician for admission.

Magellan Specifications

Children and adolescents must receive prior approval for admission to SIPP. It is recommended the provider submit the clinical information up to 7 days prior to the planned admission date but no later than 24 hours prior to admission.

Admission Service Components

1. There are no emergency admissions into a SIPP. All admissions are non-emergency and voluntary.
2. The following applies to all SIPP admissions:
 - Medical clearance must be given by a MD or physician advisor prior to admission.
 - The child or adolescent must be in good physical health (e.g., no acute medical conditions or life-threatening medical problems).
 - Acceptance of a child or adolescent with chronic illness will be a joint decision between Magellan and the provider.
 - The child or adolescent has age-appropriate cognitive ability.
 - The family has the right to refuse the referral.
 - Individuals who are in State custody may not be referred or admitted without an independent evaluation by a qualified evaluator in accordance with C 39.407, F.S., which concurs with the findings of medical necessity for this level of care.
 - The *Child and Family Staffing Form* must be reviewed prior to admission on those children not “dependent.”
 - Continued Stay Service Components:
 - Time frames for continued stay reviews include the following:
 - Enrollees under 10 years of age: Reviews shall be conducted at least every 21 days.
 - Enrollees age 10 years and over: Reviews shall be conducted at least every 30 days.
 - SIPP providers shall submit review information to Magellan Complete Care prior to the enrollee’s last certified day to request additional certification.

Specific Non-Covered Criteria

- When enrollee is receiving any other 24-hour service.
- Eligible as medically needy
- Therapeutic home assignments are not reimbursable when no service has been provided on that day.

Estimated Length of Stay and Discharge Planning:

- As specified in Rule 65E-9.010, F.A.C.:
 - The provider shall involve the child and the child's parent or guardian to the fullest extent possible at all stages of treatment planning and discharge planning toward the goal of reintegrating the child into the community.
 - The child's discharge plan shall be reviewed and, if necessary, revised during each review of the treatment plan.
 - The provider shall design individualized services and treatment for the child to address the child's presenting problems on admission with a goal of discharge to the community or to a step-down program within 120 days of admission for residential treatment centers.
- At each continued stay review, the facility should address the estimated length of stay for the enrollee and plans for discharge. There should be a basic agreement regarding length of stay and the anticipated date of discharge.
- At each continued stay review, the facility should address the anticipated placement for the child or adolescent upon discharge, the identified support services needed upon discharge, and the current status of referral and/or linkage to those services.

Note: In order to provide for continuity of care for the child, the SIPP requires that providers hold a bed for a child for up to seven days if the child is undergoing an acute medical or psychiatric admission and is expected to return to the SIPP.

References

Agency for Health Care Administration. (2015). *Statewide Inpatient Psychiatric Program Coverage Policy*. Retrieved from: https://ahca.myflorida.com/medicaid/review/specific_policy.shtml.

Certification of Need for Services, 42 C.F.R. § 441.152 1996.

Psychological Testing

Service Description

Psychological testing consists of the assessment, evaluation, and diagnosis of the recipient's mental status or psychological condition through the use of standardized testing methodologies.

Psychological testing must be administered to recipients for one of the following reasons:

- Extended hiatuses, marked changes in mental status, or assessing for
- admission or readmission to a psychiatric inpatient setting
- Onset of illness or suspected illness when a recipient first presents for treatment
- To obtain additional information needed to evaluate treatment or make a

diagnosis

Criteria for Authorization

The purpose of psychological testing includes, but is not limited to: assisting with diagnosis and management following clinical evaluation when a mental illness or psychological abnormality is suspected; providing a differential diagnosis from a range of neurological/psychological disorders that present with similar constellations of symptoms, e.g., differentiation between pseudodementia and depression; determining the clinical and functional significance of a brain abnormality; or delineating the specific cognitive basis of functional complaints.

Prior to psychological testing, the individual must be assessed by a qualified behavioral healthcare provider. The diagnostic interview determines the need for and extent of the psychological testing. Testing may be completed at the onset of treatment to assist with necessary differential diagnosis issues and/or to help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed since the institution of the initial treatment plan and there is no clear explanation for the lack of improvement.

I. Severity of Need

Criteria A, B, and C must be met:

- A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.
- B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.
- C. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment.

II. Intensity and Quality of Care

Criteria A and B must be met:

- A. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), medical psychologist (M.P.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, administers the tests.
- B. The requested tests must be standardized, valid and reliable in order to answer the specific clinical question for the specific population under consideration. The most recent version of the test must be used, except as outlined in Standards for Educational and Psychological Testing.

Exclusion Criteria

Psychological testing will not be authorized under any of the following conditions:

- A. The enrollee is not neurologically and cognitively able to participate in a meaningful way in the testing process.
- B. The test is used as screening tool given to the individual or to general populations.
- C. Administered for educational or vocational purposes that do not establish medical management.

- D. Performed when abnormalities of brain function are not suspected.
- E. Used for self-administered or self-scored inventories, or screening tests of cognitive function (whether paper-and-pencil or computerized), e.g., AIMS or Folstein Mini-Mental Status Examination.
- F. Repeated when not required for medical decision-making (i.e., making a diagnosis or deciding whether to start or continue a particular rehabilitative or pharmacologic therapy).
- G. Administered when the enrollee has a substance use background and any of the following apply:
 - a) The enrollee has ongoing substance use such that test results would be inaccurate, or
 - b) The enrollee is currently intoxicated.
 - c) The enrollee has a metabolic problem that may be interfering with cognition, such as a delirium.
- H. The enrollee has been diagnosed previously with brain dysfunction such as Alzheimer's disease, and there is no expectation that the testing would impact the enrollee's medical management.
- I. The test is being given solely as a screening test for Alzheimer's disease.
- J. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual is a candidate for a medical or surgical procedure.
- K. The testing is primarily for diagnosing attention-deficit hyperactivity disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.
- L. The testing is primarily for legal purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing.
- M. The requested tests are experimental, antiquated, or not validated.
- N. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.
- O. More than eight hours per enrollee per evaluation is considered excessive and supporting documentation in the medical record must be present to justify greater than eight hours per enrollee per evaluation.
- P. Two or more tests are requested that measure the same functional domain.
- Q. The number of hours requested for the administration, scoring, interpretation and reporting exceeds the generally accepted standard for the specific testing instrument(s), unless justified by particular testing circumstances.

- R. Testing to determine if an individual is a candidate for a specific medication or dosage is an excluded benefit.
- S. The use of structured interview tools or interviews that do not have psychometric properties or normative comparisons is not a covered benefit.

References

Agency for Health Care Administration. (2019). *Behavioral Health Assessment Services Coverage Policy*. Retrieved from:
<https://ahca.myflorida.com/medicaid/review/Specific/59G-4.028.pdf>

Bibliography

1. Barkley, R. A. (2006). *Attention-Deficit Hyperactivity Disorder: A Handbook for diagnosis and treatment* (3rd Ed.). New York: Guilford Press.
2. Cincinnati Children's Hospital Medical Center. *Evidence based clinical practice guideline for outpatient evaluation and management of attention-deficit/hyperactivity disorder*. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2004 Apr 30 :1-23.
3. Hunsley, J., & Mash, E. (2007). Evidence-based assessment. *Annual Review of Clinical Psychology*, 329-51.
4. Murphy, L. L., Spies, R. A. & Plake, B.S. (Eds.) *Tests in print VII: An index to tests, test reviews, and the literature on specific tests*. Lincoln, Neb.: Buros Institute of Mental Measurements, University of Nebraska-Lincoln, (2006).
5. Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder (2007). *Journal of American Academy Child and Adolescent Psychiatry*, 46(7). 894-921.
6. Root, R. W. & Resnick, R. J. (2003). An update on the diagnosis and treatment of attention-deficit/hyperactivity disorder in children. *Professional Psychology: Research and Practice*, 34 (1), 34-41.
7. Standards for Educational and Psychological Testing. Revised (1999) Washington, D.C.: AERA Publications. p. 48.

Neuropsychological Testing

Service Description

Neuropsychological tests are evaluations designed to determine the functional consequences of known or suspected brain dysfunction through testing of the neuro-cognitive domains responsible for language, perception, memory, learning, problem solving, adaptation, and constructional praxis.

Criteria for Authorization

These evaluations are requested for enrollees with a history of psychological, neurologic or medical disorders known to impact cognitive or neurobehavioral functioning. The evaluations include a history of medical or neurological disorders compromising cognitive or behavioral functioning; congenital, genetic, or metabolic disorders known to be associated with impairments in cognitive or brain development; reported impairments in cognitive functioning; and evaluations of cognitive function as a part of the standard of care for treatment selection and treatment outcome evaluations.

In addition, the evaluation includes a formal interview, a review of medical, educational, and vocational records, interviews with significant others, and a battery of standardized neuropsychological assessments. The testing quantifies an enrollee's higher cortical functioning and may include various aspects of attention, memory, speed of information processing, language, visual-spatial ability, sensory processing, motor ability, higher-order executive functioning, and intelligence. The goal of neuropsychological testing may be clarification of diagnosis, determination of the clinical and functional significance of a brain abnormality, or development of recommendations regarding neurological rehabilitation planning, but is always for the purpose of shaping treatment.

Neuropsychological testing should be considered for coverage through the enrollee's **mental health** benefit when:

- The referring practitioner is a psychiatrist, neuropsychologist, psychologist, or other behavioral health clinician.
- The primary diagnosis is psychiatric, even though medical problems are involved; the purpose of testing is to clarify whether it is a psychiatric diagnosis (e.g., dementia versus pseudo-dementia; head injury versus anxiety/depression; organic mood versus mood disorder not otherwise specified; or organic delusion versus schizophrenia).

Neuropsychological testing should be considered for coverage through the enrollee's **medical benefit** when:

- The referring practitioner is a neurologist, primary care physician, surgeon, or pain specialist.
- The primary diagnosis is medical (e.g., multiple sclerosis, head injury, tumors, Alzheimer's disease or stroke).

I. **Severity of Need**

Criteria A *and* B, **and one** of C-O must be met:

- A. The reason for testing must be based on a specific referral question and this specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.
- B. The testing results based on the referral question(s) are reasonably expected to provide information that will effectively guide the course of treatment.
- C. When there are mild or questionable deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes; or

- D. When neuropsychological data can be combined with clinical, laboratory, and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or
- E. When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or
- F. When there is a need for a pre-surgical or treatment-related cognitive evaluation to determine whether one might safely proceed with a medical or surgical procedure that may affect brain function (e.g., deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery or stem cell transplant) or significantly alter a enrollee's functional status; or
- G. When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (e.g., radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or
- H. When there is a need to monitor progression, recovery, and response to changing treatments, in enrollees with CNS disorders, in order to establish the most effective plan of care; or
- I. When there is a need for objective measurement of the enrollee's subjective complaints about memory, attention, or other cognitive dysfunction, which serves to determine treatment by differentiating psychogenic from neurogenic syndromes (e.g., dementia vs. depression); or
- J. When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or
- K. When there is a need to determine whether a enrollee can comprehend and participate effectively in complex treatment regimens (e.g., surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome enrollees; transplant or bariatric surgeries in enrollees with diminished capacity), and to determine functional capacity for healthcare decision-making, work, independent living, managing financial affairs, etc.; or
- L. When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured enrollees; or
- M. When there is a need to establish treatment planning through identification and assessment of the neurocognitive sequelae of systemic disease (e.g., hepatic encephalopathy or anoxic/hypoxic injury associated with cardiac procedures); or
- N. When there is a need for assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders; or
- O. When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

II. Intensity and Quality of Care

Criteria A and B must be met:

- A. Tests are administered directly by either an appropriate state-licensed provider or by a trained technician. The technician who administers the neuropsychological test must be directly supervised by the provider.
- B. Requested tests must be standardized, valid and reliable. The most recent version of the test must be used.

Neuropsychological tests include direct question-and-answer; object manipulation; inspection and responses to pictures or patterns; or paper-and-pencil written or multiple-choice tests that measure functional impairment and abilities in:

1. General intellect
2. Reasoning, sequencing, problem-solving, and executive function
3. Attention and concentration
4. Learning and memory
5. Language and communication
6. Visual-spatial cognition and visual-motor praxis
7. Motor and sensory function
8. Mood, conduct, personality, quality of life
9. Adaptive behavior (activities of daily living)
10. Social-emotional awareness and responsivity
11. Psychopathology (e.g., psychotic thinking or somatization)
12. Motivation and effort (e.g., symptom validity testing).

III. Exclusion Criteria

Neuropsychological testing will not be authorized under the following conditions:

- A. The enrollee is not neurologically and cognitively able to participate in a meaningful way in the testing process.
- B. The test is used as a screening tool given to the individual or to general populations.
- C. Administered for educational or vocational purposes that do not establish medical management.
- D. Performed when abnormalities of brain function are not suspected.
- E. Used for self-administered or self-scored inventories, or screening tests of cognitive function (whether paper-and-pencil or computerized), e.g., AIMS or Folstein Mini-Mental Status Examination.
- F. Repeated when not required for medical decision-making (i.e., making a diagnosis or deciding whether to start or continue a particular rehabilitative or pharmacologic therapy).

- G. Administered when the enrollee has a substance use background and any of the following apply:
 - 1) The enrollee has ongoing substance use such that test results would be inaccurate, or
 - 2) The enrollee is currently intoxicated.
- H. The enrollee has been diagnosed previously with brain dysfunction such as Alzheimer's disease, and there is no expectation that the testing would impact the enrollee's medical management.
- I. The test is being given solely as a screening test for Alzheimer's disease.
- J. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual is a candidate for a medical or surgical procedure.
- K. The testing is primarily for diagnosing attention-deficit hyperactivity disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.
- L. The testing is primarily for legal purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing.
- M. The requested tests are experimental, antiquated, or not validated.
- N. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.
- O. More than eight hours per enrollee per evaluation is considered excessive and supporting documentation in the medical record must be present to justify greater than eight hours per enrollee per evaluation.
- P. Two or more tests are requested that measure the same functional domain.
- Q. The number of hours requested for the administration, scoring, interpretation and reporting exceeds the generally accepted standard for the specific testing instrument(s), unless justified by particular testing circumstances.
- R. Testing to determine if an individual is a candidate for a specific medication or dosage is an excluded benefit.
- S. The use of structured interview tools or interviews that do not have psychometric properties or normative comparisons is not a covered benefit.

IV. Standardized Cognitive Testing

- A. Cognitive testing is considered a type of neuropsychological testing.
- B. Cognitive testing is authorized in compliance with CMS coding rules:
 - 1. Billing is limited to two hours on the same date of service.

Bibliography

1. American Academy of Clinical Neuropsychology (2010). *AACN response to AMA/PCPI Dementia Performance Measurement Set*. Retrieved 7/26/2011.
2. American Academy of Clinical Neuropsychology (2011). AACN letter to the Wisconsin Physicians Service on LCD. Retrieved 7/26/2011.
3. American Medical Association (2006). *CPT Assistant*. American Medical Association.
4. American Psychological Association (2010). Ethical Principles of Psychologists and Code of Conduct. Retrieved 7/30/2011.
5. Baars, M. A. E., van Bostel, M. P. J., Dijkstra, J. B., Visser, P. J., van den Akker, M., Verhey F. R. J. et al., (2009). Predictive value of mild cognitive impairment for dementia. *Dementia and Geriatric Cognitive Disorders*, 27, 173-181.
6. Beck I, Gagneux-Zurbriggen A, Berres M, Taylor K, Monsch A. Comparison of verbal episodic memory measures: consortium to establish a registry for Alzheimer's disease Neuropsychological Assessment Battery (CERAD-NAB) versus California Verbal Learning Test (CVLT). *Archives Of Clinical Neuropsychology: The Official Journal Of The National Academy Of Neuropsychologists* [serial online]. August 2012;27(5):510-519. Available from: MEDLINE Complete, Ipswich, MA. Accessed January 2, 2015.
7. Cosentino, S., Metcalfe, J., Cary, M., De Leon, J., & Karlawish, J. (2011). Memory awareness influences everyday decision making capacity about medication management in Alzheimer's disease. *International Journal of Alzheimer's Disease*, Article ID 483897, 9 pages.
8. Cummings, J., Jones, R., Wikinson, D. Lopez, O. et al (2010). Effect of donepezil on cognition in Alzheimer's disease: a pooled data analysis. *Journal of Alzheimer's Disease*, 21, 843-851.
9. Farias, S. T., Harrell, E., Neumann, C., & Houtz, A. (2003). The relationship between neuropsychological performance and daily functioning in individuals with Alzheimer's disease: ecological validity of neuropsychological tests. *Archives of Clinical Neuropsychology*, 18, 655-672.
10. Ferman, T. J., Smith, G. E., Boeve, G. F., Graff-Radford, N. R., Lucas, J. A., Knopman, D. S., et al. (2006) Neuropsychological differentiation of dementia with Lewy Bodies from normal aging and Alzheimer's disease. *Clinical Neuropsychologist*, 20, 623-636.
11. Gavett, B. E., Lou, K. R., Daneshvar, D. H., Green, R. C., Jefferson, A. L., & Stern, R. A. (2012). Diagnostic accuracy statistics for seven Neuropsychological Assessment Battery (NAB) test variables in the diagnosis of Alzheimer's disease. *Applied Neuropsychology. Adult*, 19(2), 108-115.

12. Jak, A. J., Bondi, M. W., Delano-Wood, L., Wierenga, C., Corey-Bloom, J., Salmon, D. P., et al. (2009). Quantification of five neuropsychological approaches to defining mild cognitive impairment. *American Journal of Geriatric Psychiatry*, 17, 368-375.
13. Mittelman M.S., Haley, W. E., Clay, O. J., & Roth, D. L. (2006). Improving caregiver well-being delays nursing home placement of enrollees with Alzheimer's disease. *Neurology*, 67, 1592-1599.
14. *Neuropsychology Model LCD Taskforce*, a national workgroup representing The American Academy of Clinical Neuropsychology (AACN), the American Psychological Association (APA) Division of Clinical Neuropsychology, and the National Academy of Neuropsychology (NAN), 011.

Community Behavioral Health Services

a. Clubhouse Services – Adult (H2030)

Service Description

Clubhouse services provide structured, community-based services delivered in a group setting that utilize behavioral, cognitive, or supportive interventions to improve a recipient's potential for establishing and maintaining social relationships and obtaining occupational or educational achievements.

Clubhouse services consist of social, educational, pre-vocational and transitional employment rehabilitation utilized to assist the recipient with the following:

- Eliminating functional, interpersonal, and environmental barriers
- Restoring social skills for independent living and effective life management
- Facilitating cognitive and socialization skills necessary for functioning in a work environment

Clubhouse services are rehabilitative and utilize a wellness model to restore independent living skills. They must be delivered in a group setting that cannot exceed 12.

Florida Medicaid recipients must be at least 16 years old to receive Clubhouse services.

Admission Criteria

(Must meet *all* of the following):

1. Be at least 16 years of age.
2. The presence of a serious mental illness, based upon medical records, which includes an ICD 10 diagnosis by a psychiatrist.
3. As a result of the mental illness, the enrollee has a moderate to severe functional impairment that interferes with or limits his/her performance in at least one (1) of the following domains:
 - a. educational (i.e., obtaining a high school or college degree);
 - b. social (i.e., developing a social support system);
 - c. vocational (i.e., obtaining part time or full time employment);
 - d. self-maintenance (i.e., managing symptoms, understanding their illness, managing money, living more independently) relative to the enrollee's ethnic/cultural environment; *and*
3. The enrollee chooses to participate in the program.

Continued Stay Criteria

(Must meet *both* of the following):

1. Continue to meet medical necessity criteria for this level of care defined in above Admission Criteria.
2. There is a reasonable expectation that the enrollee will benefit from the continuation of the program.
3. The enrollee chooses to continue participation in the program.

Exclusion Criteria:

(Any one of the following)

1. Enrollee is under 16 years of age.
2. Enrollee's identified problem is primarily social, financial, and/or medical (non-psychiatric) in the absence of a primary psychiatric diagnosis.
3. Enrollee does not have the intent of nor is capable of moving toward independent living.
4. Enrollee's symptoms include imminent risk of potential harm to self, others or property.
5. Enrollee has not received medical clearance to participate due to unstable medical conditions.
6. Medicaid does not reimburse for community behavioral health services for treatment of a cognitive deficit severe enough to prohibit the service from being of benefit to the recipient

Magellan Specifications

Service Limitations: Medicaid reimburses clubhouse services for a maximum of 1920 quarter-hour units (480 hours; 20 days) annually, per recipient, per state fiscal year. These units count against psychosocial rehabilitation units of service. Services in excess of the limits will be reviewed for medical necessity.

b. Therapeutic Behavioral On-Site Services - Child and Adolescent (H2019 HO, H2019 HM, H2019 HN)

Service Description

Intensive, individualized, one-to-one services coordinated through treatment teams and an individual's family, designed to prevent an individual from requiring placement in more intensive and restrictive behavioral health settings through therapy, behavior management, and therapeutic support services.

Covered for recipients under the age of 21 years requiring medically necessary therapeutic behavioral on-site services (TBOS).

Admission Criteria

(Must meet one of the following)

1. Enrolled in a special education program for the seriously emotionally disturbed (SED) or the emotionally handicapped
2. Scored 60 or below on the Children's Global Assessment of Functioning Scale within the last 6 months
3. There is evidence to indicate that the recipient is at risk for a more intensive, restrictive, and costly behavioral health placement
4. There is evidence to indicate that the recipient's condition and functional level cannot be improved with a less intensive service such as individual or family therapy or group therapy

Continued Stay Criteria

(Must meet 1 through 4 and either 5 or 6)

1. Enrollee continues to meet the criteria defined in above Admission Criteria.
2. The members of a recipient's treatment team must document that the recipient continues to meet the eligibility criteria stated above within six months of the original determination of eligibility for services, and every six months thereafter.

Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Case management services
- Partial hospitalization
- Personal care services
- Psychological testing, neuropsychology, psychotherapy, cognitive behavioral therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services not listed on the Community Behavioral Health fee schedule
- Services provided to a recipient on the date of admission into the Statewide Inpatient Psychiatric Program

- Therapeutic behavioral on-site services delivered in an inpatient setting
- Therapeutic behavioral on-site services on the same day as behavioral health day treatment, behavior analysis services, therapy services, group therapy, psychosocial rehabilitation, therapeutic foster care, therapeutic group care, or behavioral health overlay services
- Therapeutic behavioral on-site therapy and behavior management services delivered in a group setting
- Travel time
- Tutoring and academic support

Magellan Specifications

Providers must deliver TBOS in community settings, including the home and school.

Therapeutic behavioral on-site services consist of behavior management, support, and therapy services, as follows:

–Up to nine hours of behavior management services per month, per recipient that consist of all of the following:

- Continuous monitoring and assessment of interactions that motivate, maintain, or improve recipient behavior and the skill deficits and assets of the recipient and recipient’s family
- Development of an individual behavior plan with measurable goals that must be integrated into the treatment plan
- Training the recipient’s family, caregivers, and other individuals involved in implementing the treatment plan
- Measuring the recipient’s progress toward meeting the goals listed on the treatment plan
- Coordinating services listed on the treatment plan

–Up to 32 hours of therapeutic support services per month, per recipient that consist of all of the following:

- One-to-one supervision and intervention with the recipient during therapeutic activities in accordance with the treatment plan
- Providing skills training in accordance with the recipient’s treatment plan to improve the recipient’s functioning and restore basic living and social skills
- Assistance to the recipient and his or her family with implementing the treatment plan through family counseling and treatment plan development

–Up to nine hours of therapy services per month, per recipient that consist of all of the following:

- Clinical, strength-based assessment to evaluate, define, and determine treatment needs
- Individual and family therapy
- Assessment and engagement of the recipient and his or her family’s natural support system to assist with implementing the treatment plan
- Collaborative development of the formal aftercare plan

Providers must complete a formal aftercare plan within 45 days of admission to TBOS. The aftercare plan must include community resources, activities, services, and supports that will sustain the gains achieved by the recipient during treatment.

Once every six months following the original determination of eligibility for TBOS, the individualized treatment team must document whether the recipient continues to meet the criteria to receive TBOS. If the recipient receives a reassessment determining that he or she is no longer eligible, Florida Medicaid will cease covering TBOS.

Reference

Agency for Health Care Administration. (November 2019). *Behavioral Health Intervention Services Coverage Policy*. Retrieved from:
<https://ahca.myflorida.com/medicaid/review/Specific/59G-4.370.pdf>

Behavioral Health Overlay Service (BHOS- H2020 HA)

Service Description

Behavioral health overlay services include mental health, substance use, and supportive services designed to meet the behavioral health treatment needs of recipients in the care of Medicaid enrolled, certified agencies under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization.

The intent of behavioral health overlay services is the maximum reduction of the recipient's disability and restoration to the best possible functional level in order to avoid a more intensive level of care. Services must be diagnostically relevant and medically necessary. Services must be included in an individualized treatment plan that has been approved by a treating practitioner.

Behavioral health overlay services include the following components:

- Therapy
- Behavior management
- Therapeutic support

Admission Criteria

(Must meet all criteria in Section A and at least one risk factor in Section B)

Section A: Diagnostic Criterion

The enrollee is under the age of 21 years and has an emotional disturbance or a serious emotional disturbance (ICD 10 diagnosis).

Section B: Risk Factors (must meet at least one)

The enrollee must be at risk due to one of the following factors in the last 12 months:

1. Has exhibited suicidal gestures or attempts, or self-injurious behavior or current ideation related to suicidal or self-injurious behavior, and is not currently in need of acute care.
2. Has exhibited physical aggression or violent behavior toward people, animals, or property; this risk may also be evidenced by current threats of such aggression.
3. Has run away from home or placements or threatened to run away on one or more occasions.
4. Has had an occurrence of sexual aggression.
5. Has experienced trauma.

The enrollee's risk factor(s) must be documented and detailed on the Certification of Eligibility and reflected in the enrollee's treatment plan.

Continued Stay Criteria:

1. Enrollee must continue to meet the admission criteria.
2. There is a reasonable expectation that the enrollee will benefit from the continuation of services.

Exclusion Criteria

1. Medicaid does not reimburse for behavioral health overlay services for treatment of a cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.

Discharge Criteria

(Must meet all of the following):

1. Enrollee no longer meets Continued Stay Criteria.
2. Enrollee meets the individualized, measurable discharge criteria developed in collaboration with enrollee.

Definitions

Emotional Disturbance: A person under the age of 21 years who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation.

Serious Emotional Disturbance: A person under the age of 21 years who is all of the following:

- Diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Exhibits behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation

Shelter Status: The legal status that begins when a recipient under the age of 18 years is taken into the protective custody of the Department of Children and Families (DCF) and ceases when one of the following occurs:

- Court grants custody to a parent.
- After disposition of the petition for dependency.
- Court orders the child to be released to a parent or placed in the temporary custody of a relative, a nonrelative, or DCF.

Magellan Specifications

Behavioral Health Overlay Services Exclusions

The following are services and supports not reimbursed under behavioral health overlay services:

- Services provided to a recipient on the day of admission into a statewide inpatient psychiatric program. However, community behavioral health services are reimbursable on the day of discharge.
- Case management services.
- Partial hospitalization.
- Services rendered to individuals residing in an institution for mental diseases.
- Services rendered to institutionalized individuals, as defined in 42 CFR 435.1009.
- Room and board expenditures.
- Travel time.
- Education services.
- Activities performed to maintain and review records for facility utilization, continuous quality improvement, recipient eligibility status processing, and staff training purposes.
- Activities (other than record reviews, services with family member or other interested person that benefit the recipient, or services performed using telemedicine) that are not performed face-to-face with the recipient.
- Services rendered by a recipient's relative.
- Services rendered by unpaid interns or volunteers.
- Services paid for by another funding source.
- Escorting or transporting a recipient to and from a service site.

Mental health targeted case management cannot be billed in conjunction with behavioral health overlay services.

Service Limits

- Medicaid will reimburse for behavioral health overlay services for up to 365 days per recipient, per state fiscal year (July 1 through June 30).
- Medicaid will not reimburse for the same procedure code twice in one day.
- Medicaid will not reimburse for behavioral health overlay services when a recipient is absent because he or she is in a Department of Juvenile Justice detention center placement.
- Medicaid will not reimburse a provider for behavioral health overlay services if the provider has been paid for the provision of the same type of services by another purchasing entity.

Therapeutic Home Assignments

- Therapeutic home assignments are overnight stays the recipient spends with the biological, adoptive or extended family, or in a potential placement in order to practice the generalized skills learned in treatment to the recipient's home or other natural settings. Therapeutic home assignments may include time spent away overnight with friends, school, or club activities.

- Therapeutic home assignments are planned in conjunction with the recipient's treatment goals and objectives. Therapeutic home assignments must be prior authorized and must be prescribed on the recipient's treatment plan.
- The provider agency must be accessible and must maintain a level of communication with the recipient during therapeutic home assignments.
- Telephone communication can be utilized to maintain on-going communication with the recipient during therapeutic home assignments
- Reimbursement: Medicaid reimburses up to 10 therapeutic home assignments per calendar quarter (three months). During the last three months of placement, and if the therapeutic home assignments are in accordance with the recipient's aftercare plan, Medicaid can reimburse for up to 20 therapeutic home assignments. The therapeutic home assignments must be authorized in the recipient's treatment plan.

References

Agency for Health Care Administration. (2014). *Behavioral Health Overlay Services Coverage and Limitations Handbook*. Retrieved from: https://ahca.myflorida.com/medicaid/review/specific_policy.shtml.

Therapeutic Group Care Services (H0019)

Service Description

Florida Medicaid therapeutic group care (TGC) services provide community-based residential, behavioral health treatment to increase coping skills and functional abilities and reduce psychiatric symptoms or disruptive behaviors, enabling recipients to return to a less restrictive environment.

Therapeutic group care services is designed for recipients under the age of 21 years with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 recipients under the age of 21 years.

Admission Criteria

(Must meet all of the following):

1. The multidisciplinary treatment team must confirm, in writing, that the member is appropriate for therapeutic group care placement by a licensed clinical psychologist or a board-certified psychiatrist.
2. There is justification that the individualized programming and interventions cannot be safely and/or effectively furnished at a non-residential level of care.
3. Has an emotional disturbance or serious emotional disturbance.

Continued Stay Criteria

(Must meet 1 through 3)

1. The multidisciplinary team must recommend Specialized Therapeutic Group Care no less than every six months.

2. The focus of services must be directly related to the member's mental health or substance use condition.
3. The intensity and individual utilization of treatment services must be determined by, and must be directly related to, the member's specific needs as identified in the individualized treatment plan. Services must be provided in accordance with the member's individualized treatment plan and reflected in the clinical record.

Exclusion Criteria

(Any one of the following)

1. The member's functional and behavioral problems are primarily related to cognitive or developmental disabilities.
2. Medicaid does not reimburse for specialized therapeutic services for treatment of a cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.
3. Member has medical issues that prevent utilization of therapeutic group care services.
4. Member is not likely to benefit from treatment in this Level of Care.
5. Member's behavioral issues are not secondary to a DSM5 disorder that typically responds to psychosocial interventions outside of a secure facility.

Discharge Criteria (Must meet all of the following)

1. The symptoms/behaviors that precipitated admission have sufficiently improved so that the member can be maintained at a lesser level of care and enrollee will not be compromised with treatment being given at a less intensive level of care.
2. A comprehensive discharge plan has been developed.
3. Discharge is not likely to interfere with gains achieved while in therapeutic group care services.

Definitions:

Multidisciplinary Team (MDT):

A MDT consists of a representative from the Department of Children and Families (DCF), or its designee, the local Medicaid area office, or the Department of Juvenile Justice (when applicable). Other MDT members should include the recipient, the recipient's case manager, a representative from the recipient's school, the recipient's biological or adoptive parents or relatives, the foster care parents or emergency shelter staff, assigned counselors or case managers, a health plan representative and the recipient's medical health care provider.

Serious emotional Disturbance:

A person under the age of 21 years who is all of the following:

- Diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

- Exhibits behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation.

Magellan Specifications:

- Reviews shall be conducted every 30 days.
- Providers shall submit continued stay prior authorization request and clinical information to Magellan Complete Care prior to the enrollee's last certified day.
- Florida Medicaid covers up to 365/6 days of TGC treatment services per year, per recipient.
- Providers must provide the care and services required for a recipient to attain or restore the highest practicable physical, mental, and psychosocial well-being in accordance with Rule Chapter 65E-9, F.A.C., as follows:
 - Aftercare and follow-up services
 - Behavior analysis services
 - Coordination with the recipient's primary care physician(s)
 - Education services in accordance with Rule 6A-6.0361, F.A.C.
 - Family therapy services
 - Individualized treatment plan developed within 14 days after admission
 - Individual and group therapy services
 - Psychiatric, psychological, substance use, and biopsychosocial assessments and monitoring
 - Recreational services
 - Rehabilitative services
 - Therapeutic home assignment
 - Vocational services (for recipients ages 16 years and older)
- Therapeutic home assignments require daily clinical intervention with the family by the recipient's physician, primary therapist, certified behavior analyst, or other licensed practitioner.

Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Individual, family or group therapy, or behavior analysis services, reimbursed separately
- Room and board
- Services on days when a recipient is on therapeutic home assignment and no clinical intervention is provided
- Services provided to a recipient on the day of admission into the Statewide Inpatient Psychiatric Program
- Services when the recipient is receiving any other 24-hour per day Florida Medicaid residential or institutional service
- Services on the date of discharge

References

Specialized Therapeutic Foster Care Services

Service Description

Specialized therapeutic foster care services are intensive treatment services provided to recipients under the age of 21 years with emotional disturbances who reside in a state licensed foster home. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention.

The goal of specialized therapeutic foster care is to enable a recipient to manage and to work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting.

The three specialized therapeutic foster care services available are listed below. Intensity depends upon the needs of the enrollee:

- Specialized Therapeutic Foster Care, Level I;
- Specialized Therapeutic Foster Care, Level II; and
- Crisis Intervention

Admission Criteria –

Level I (Must meet 1-3)

1. An emotional disturbance or serious emotional disturbance, including a mental, emotional or behavioral disorder as diagnosed by a psychiatrist or other licensed practitioner of the healing arts. Without specialized therapeutic foster care, the enrollee would require admission to a psychiatric hospital, the psychiatric unit or a general hospital, a crisis stabilization unit or a residential treatment center or has, within the last two years, been admitted to one of these settings.
- 2a. A history of delinquent acts and has a serious emotional disturbance. The enrollee may exhibit maladaptive behaviors such as destruction of property, aggression, running away, use of illegal substances, lying stealing, etc. The enrollee may display impaired self-concept, emotional immaturity or extreme impulsiveness, and immaturity impairs decision-making and places the enrollee at risk in a non-therapeutic community setting;

Or

- 2b. A history of abuse or neglect.
3. Been determined by the multi-disciplinary team that the enrollee cannot be adequately treated with less intensive services.

Admission Criteria

Level II

(Must meet Admission Criteria for Level I and the following 4th criteria)

4. Level II is for an enrollee who meets the criteria for Level I and who exhibits more severe maladaptive behaviors such as destruction of property, physical aggression toward people or animals, self-inflicted injuries, and suicide indications or gestures, or

an inability to perform activities of daily and community living due to psychiatric symptoms. The enrollee requires more intensive therapeutic interventions and the availability of highly trained specialized therapeutic foster parents.

Admission Criteria

Crisis Intervention Services

(Must meet the following)

1. Specialized therapeutic foster care services may be used for crisis intervention for an enrollee for whom placement must occur immediately in order to stabilize a behavioral, emotional, or psychiatric crisis. The enrollee must be in foster care or commitment status and meet Level I or Level II criteria.

Continued Stay Criteria

(for Level I, II, and Crisis Intervention):

1. The multi-disciplinary team must determine the level of specialized therapeutic foster care services required by the enrollee, and review each child/adolescent's status to re-authorize services no less than every six months. A specialized therapeutic foster home may be used as a temporary crisis intervention placement for a maximum of 30 days. Any exception to this length of stay must be approved in writing by the multidisciplinary team.

Exclusion Criteria:

(Any one of the following):

1. The enrollee's functional and behavioral problems are primarily related to cognitive or developmental disabilities.
2. Enrollee has medical issues that prevent utilization of specialized therapeutic foster care.

Discharge Criteria:

(Must meet 1 and 2):

1. The symptoms/behaviors that precipitated admission have sufficiently improved so that the enrollee can be maintained at a lesser level of care and enrollee will not be compromised with treatment being given at a less intensive level of care.
2. A comprehensive discharge plan has been developed in consideration of: Enrollee's strengths, social and/or familial support system, resources and skills, identification of triggers for relapse; and other factors/obstacles to improvement, and

Definitions

Multidisciplinary Team (MDT)

The role of the MDT is to assess whether the recipient is appropriate for specialized therapeutic foster care (STFC). A MDT consists of a representative from the Department of Children and Families (DCF), or its designee, the local Medicaid area office, or the Department of Juvenile Justice (when applicable). Other MDT members should include the recipient, the recipient's case manager, a representative from the recipient's school, the recipient's biological or adoptive parents or relatives, the foster care parents or emergency shelter staff, assigned counselors or case managers, a health plan representative and the recipient's medical health care provider.

Serious Emotional Disturbance

A person under the age of 21 years who is all of the following:

- Diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Exhibits behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation.

Magellan Specifications

Specialized therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological, and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician, and a psychiatrist. A specialized therapeutic foster parent must be available 24 hours per day to respond to crises or to provide special therapeutic interventions.

Specialized Therapeutic Foster Care Levels of Service

There are two levels of specialized therapeutic foster care, which are differentiated by the supervision and training of the foster parents and intensity of programming required. Specialized therapeutic foster care levels are intended to support, promote competency, and enhance participation in normal, age-appropriate activities of recipients who present moderate to serious emotional or behavior management problems.

Programming and interventions are tailored to the age and diagnosis of the recipients. Specialized therapeutic foster care services are offered at Level I or Level II, with crisis intervention available at both levels.

Level I Specialized Therapeutic Foster Care: is characterized by close supervision of the recipient within a specialized therapeutic foster home. Services to the recipient must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician, and a psychiatrist.

Level II Specialized Therapeutic Foster Care: is characterized by the need for more frequent contact between the specialized therapeutic foster parents, the recipient, primary clinician, and the psychiatrist as a result of the recipient exhibiting the maladaptive behaviors listed below. Level II specialized therapeutic foster care is intended to provide a high degree of structure, support, supervision, and clinical intervention.

Crisis Intervention Services: Specialized therapeutic foster care services may be used for crisis intervention for an enrollee for whom placement must occur immediately in order to stabilize a behavioral, emotional or psychiatric crisis. The member must meet criteria.

Authorization for Specialized Therapeutic Foster Care Services

The multidisciplinary team must authorize specialized therapeutic foster care services. The multidisciplinary team must re-authorize specialized therapeutic foster care services no less than every six months.

Written documentation to support the multidisciplinary team's recommendation must be submitted to the plan along with Prior Authorization request form.

Documentation of an MDT staffing must contain:

- Documentation of the date of the MDT staffing.

- Documentation of participants (compliant with the MDT definition in the Handbook)
- Relevant notes from the staffing

References

Agency for Health Care Administration. (2014). *Specialized Therapeutic Services Coverage and Limitations Handbook*. Retrieved from:
https://ahca.myflorida.com/medicaid/review/specific_policy.shtml

Exclusions for Community Behavioral Health Services, Behavioral Health Overlay Services and Specialized Therapeutic Services

The following are services and supports not reimbursed under community behavioral health services:

- Services provided to a recipient on the day of admission into the Statewide Inpatient Psychiatric Program (SIPP); however, community behavioral health services are reimbursable on the day of discharge
- Case management services
- Partial hospitalization
- Services rendered to individuals residing in an institution for mental diseases
- Services rendered to institutionalized individuals, as defined in 42 CFR 435.1009
- Basic childcare programs for developmental delays, preschool, or enrichment programs
- Travel time
- Activities performed to maintain and review records for facility utilization, continuous quality improvement, recipient eligibility status processing, and staff training purposes
- Activities (other than record reviews, services with family member or other interested persons that benefit the recipient, or services performed using telemedicine) that are not performed face-to-face with the recipient, except those defined as:
 - Services rendered by a recipient's relative
 - Services rendered by unpaid interns or volunteers
 - Services paid for by another funding source
 - Escorting or transporting a recipient to and from a service site

Mental Health Targeted Case Management

a. Adult (T1017)

Service Description

Adult mental health targeted case management services assist recipients in gaining access to needed financial and insurance benefits, employment, medical, social, education, assessment of functional abilities and needs, and other services. These supportive services include working with the recipient and the recipient's natural support system to develop and implement the recipient's service plan. They also include follow-up to determine the status of the recipient's services, and the effectiveness of activities related to the successful implementation of the service plan toward enhancing the recipient's inclusion in the community

Adult mental health targeted case management for recipients age 18 years and older.

Admission Criteria

(Must meet 1 through 8; or 9)

1. Is enrolled in a DCF adult mental health target population (18 years and older);
2. Has a mental health disability (i.e., severe and persistent mental illness) that requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self-sufficiency and satisfaction in the living, learning, work, and social environments of choice;
4. Lacks a natural support system for accessing needed medical, social, educational, and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., severe and persistent mental illness) that, based upon professional judgment, will last for a minimum of one year;
7. Is not receiving duplicate case management services from another provider; and
8. Meets at least one of the following requirements:
 - a. Is awaiting admission to or has been discharged from a state mental health treatment facility;
 - b. Has been discharged from a mental health residential treatment facility;
 - c. Has had more than one admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities within the past 12 months;
 - d. Is at risk of institutionalization for mental health reasons; or
 - e. Is experiencing long-term or acute episodes of mental impairment that may put him at risk of requiring more intensive services

Or

9. If enrollee has relocated from a DCF district or region where he was receiving mental health targeted case management services, the recipient does not need to meet the above criteria. This must be documented in the recipient's case record.

Continued Stay Criteria

(Must meet 1 through 4)

1. Enrollee continues to meet medical necessity criteria for this level of care.
2. There is a reasonable expectation that the enrollee will benefit from continuing Case Management. This is observable as a positive or beneficial response to services which may include, but are not limited to:
 - a. Consistently attending scheduled therapy sessions/Case Management meetings,
 - b. Independent living and community integration,
 - c. Vocational/educational participation,
 - d. Reduced hospital lengths of stay,
 - a. Reduced use of crisis-only services.
3. Enrollee is making progress to the extent possible toward goals and is benefiting from the service plan as evidenced by lessening of symptoms and stabilization of

psychosocial functioning through Case Management Services or removal of services would result in enrollee's destabilization.

4. Techniques employed in Case Management are time limited in nature and subordinate to a goal of enhanced enrollee autonomy.

Exclusion Criteria

(Any one of the following):

1. Enrollee or enrollee's representative does not accept Mental Health Targeted Case Management (MHTCM).
2. MHTCM is not endorsed by the enrollee's primary mental health providers.
3. Enrollee does not meet the Admission guidelines for MHTCM.
4. Enrollee is residing in a nursing facility, state psychiatric hospital, or intermediate care facility for the developmentally disabled.
5. Enrollee is enrolled in FACT.
6. Diagnosis of primary substance disorder or developmental disability disorder.

Discharge Criteria

(Must meet 1 and 2)

1. Enrollee no longer meets continued stay criteria.

b. Child and Adolescent (T1017 HA)

Service Description

Children mental health targeted case management services assist recipients in gaining access to needed financial and insurance benefits, employment, medical, social, education, assessment of functional abilities and needs, and other services. These supportive services include working with the recipient and the recipient's natural support system to develop and implement the recipient's service plan. They also include follow-up to determine the status of the recipient's services, and the effectiveness of activities related to the successful implementation of the service plan toward enhancing the recipient's inclusion in the community.

Children mental health targeted case management for recipients age birth through 17 years old.

Admission Criteria

(Must meet 1-8; or 9)

1. Is enrolled in a Department of Children and Families (DCF) children's mental health target population (birth through 17 years);
2. Has a mental health disability (i.e., serious emotional disturbance) that requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self-sufficiency and satisfaction in the living, learning, work, and social environments of choice;

4. Lacks a natural support system for accessing needed medical, social, educational, and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., serious emotional disturbance) that based upon professional judgment, will last for a minimum of one year;
7. Is in out-of-home mental health placement or at documented risk of out-of home mental health treatment placement; and
8. Is not receiving duplicate case management services from another provider.

Or

9. If the recipient has relocated from a DCF district or region where he was receiving mental health targeted case management services, the recipient does not need to meet the above criteria. This must be documented in the recipient's case record.

Continued Stay Criteria (Must meet 1 through 4)

1. Enrollee continues to meet medical necessity criteria for this level of care.
2. There is a reasonable expectation that the enrollee will benefit from continuing Case Management. This is observable as a positive or beneficial response to services which may include, but are not limited to:
 - a. Consistently attending scheduled therapy sessions/Case Management meetings,
 - b. Family and community integration,
 - c. Vocational/educational participation,
 - d. Reduced hospital lengths of stay or child out-of-home placement,
 - e. Reduced use of crisis-only services.
3. Enrollee is making progress to the extent possible toward goals and is benefiting from the service plan as evidenced by lessening of symptoms and stabilization of psychosocial functioning through Case Management Services or removal of services would result in enrollee's destabilization.
4. Techniques employed in Case Management are time limited in nature and subordinate to a goal of enhanced enrollee autonomy.

Exclusion Criteria (Any one of the following):

1. Enrollee or enrollee's representative does not accept Mental Health Targeted Case Management (MHTCM).
2. MHTCM is not endorsed by the enrollee's primary mental health providers.
3. Enrollee does not meet the Admission guidelines for MHTCM.
4. Diagnosis of primary substance disorder or developmental disability disorder.

Discharge Criteria

1. Enrollee no longer meets continued stay criteria.

c. Intensive Case Management (T1017 HK)

Service Description

Intensive Case Management (ICM) Services mental health targeted case management services assist recipients in gaining access to needed financial and insurance benefits, employment, medical, social, education, assessment of functional abilities and needs, and other services. These supportive services include working with the recipient and the recipient's natural support system to develop and implement the recipient's service plan. They also include follow-up to determine the status of the recipient's services, and the effectiveness of activities related to the successful implementation of the service plan toward enhancing the recipient's inclusion in the community.

Intensive case management team services provide team case management to adults with serious and persistent mental illness to assist the recipient to remain in the community and avoid institutional care.

Intensive case management team services is for recipients age 18 years and older.

Admission Criteria

(Must meet 1-8 or 9)

1. Is enrolled in a DCF adult mental health target population (18 years and older); and
2. Has a disability which requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self-sufficiency and satisfaction in the living, learning, work, and social environments of choice;
4. Lacks a natural support system with the ability to access needed medical, social, educational, and other services;
5. Requires ongoing assistance to access or maintain needed care consistently with the service delivery system;
6. Has a disability duration that, based upon professional judgment, will last for a minimum of one year;
7. Not receiving duplicate Case Management services from another provider.
8. Meets at least one of the following requirements:
 - a. Has resided in a state mental hospital for at least 6 months in the past 36 months;
 - b. Resides in the community and has had two or more admissions to a state mental hospital in the past 36 months;
 - c. Resides in the community and has had three or more admissions to a crisis stabilization unit (CSU), and/or 24-hour level of care settings within the past 12 months.

- d. Resides in the community and, due to a mental illness, exhibits behavior or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided or;
9. Has relocated from a Department of Children and Families districts where he or she was receiving intensive Case Management team services.

Continued Stay Criteria

(Must meet 1 through 4)

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

Exclusion Criteria

(Any one of the following)

1. Enrollee does not accept ICM service.
2. ICM not endorsed by enrollee's primary mental health providers and enrollee not willing to seek alternative sources.
3. Receiving duplicative case management services from another provider.
4. Enrollee is currently in a supervised living setting or treatment plan includes return to a supervised living setting (e.g., residential treatment).
5. Enrolled in FACT.

Discharge Criteria

Enrollee no longer meets continued stay criteria.

d. Mental Health Targeted Case Management Restrictions

- **Services Provided by More Than One Case Manager:** Medicaid will not reimburse mental health targeted case management services provided by more than one case manager to the same recipient on the same date of service except in those cases described under “exceptions to a single targeted case manager per recipient” in the AHCA Mental Health Targeted Case Management Handbook.
- **Direct Service Provision:** Medicaid will not reimburse mental health targeted case management services for the provision of direct therapeutic medical or clinical services (e.g., checking blood pressure, measuring height and weight, or providing psychotherapy)
- **Administrative Functions:** Medicaid will not reimburse mental health targeted case management services for administrative functions (e.g., checking recipient eligibility or clerical duties)

Recipients Receiving FACT Services: Medicaid recipients enrolled in the Florida Assertive Community Treatment. (FACT) program funded through Medicaid administrative matching may not receive any fee-for-service Medicaid mental health targeted case management services. This would constitute a duplication of payment

- **Home and Community-Based Waiver Recipients:** Except for the Model Waiver, Medicaid will not reimburse mental health targeted case management services for recipients who are enrolled in a home and community-based services waiver program. Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on home and community-based services waiver programs
- **Institutionalized Recipients:** Medicaid will not reimburse mental health targeted case management services for recipients who are in nursing facilities, state mental health treatment facilities, county jails, prisons, detention centers, other secure residential correction facilities, or intermediate care facilities for the developmentally disabled
- **Institutions for Mental Diseases:** Medicaid does not reimburse for mental health targeted case management services rendered to a resident of an institution for mental diseases (IMD), unless the resident is participating in the Statewide Inpatient Psychiatric Program Waiver. Per Title 42, Code of Federal Regulations, Part 441.13, an institution for mental disease is defined as a hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with behavioral diseases. Note: The Code of Federal Regulations is available on the Internet at www.gpoaccess.gov/cfr/index.html
- **Discharge Planning:** Medicaid will not reimburse mental health targeted case management for discharge planning services when discharge planning is covered by a residential facility’s per diem
- Medicaid will reimburse for discharge planning for a recipient coming out of a state mental health treatment facility 60 days prior to discharge.

- **Statewide Inpatient Psychiatric Program (SIPP) Recipients:** Medicaid will reimburse targeted case management services for children in a Statewide Inpatient Psychiatric Program (SIPP) for the last 180 days prior to a planned discharge date that is documented in the medical record. For continuity, targeted case management services must be provided by a targeted case management provider agency located in the same district as the child's aftercare placement. **Supervision** Medicaid will not reimburse for internal supervision between the mental health targeted case management supervisor and the mental health targeted case manager
- **Behavioral Health Overlay Services Recipients:** Medicaid will not reimburse mental health targeted case management services for children who are receiving behavioral health overlay services under the Medicaid Community Behavioral Health Services Program, except for case management activities clearly done in preparation for the child's discharge from behavioral health overlay services (last 90 days).
- **Incomplete Assessment or Service Plan:** Medicaid will not reimburse mental health targeted case management services provided to a recipient who does not have a written assessment and current service plan developed in accordance with the requirements in this chapter.
 - Note: See Assessment and Service Plan requirements (AHCA Mental Health Targeted Case Management Handbook)
- **No Recipient Contact:** Medicaid will not reimburse for mental health targeted case management services for unsuccessful attempts to contact the recipient, e.g., a home visit when the recipient is not at home, a phone call when the recipient does not answer, or leaving a message on voice mail, e-mail, or an answering machine.
- **Duplication of Services:** Medicaid will not reimburse mental health targeted case management services:
 - If the Medicaid reimbursement for mental health targeted case management would duplicate payments for the same services through another funding source.
 - If the services overlap with or are duplicative of mental health targeted case management services provided to the recipient by the same agency or by any other agency. All Medicaid case managers associated with a recipient must coordinate with each other to ensure non-duplication of services.
 - For a targeted case manager simply being present during a face-to-face therapeutic activity
- **Transportation:** Medicaid will not reimburse mental health targeted case management provider agencies for transporting recipients. The Medicaid transportation program provides transportation for Medicaid recipients to medically necessary, Medicaid-compensable services. Medicaid contracts with a vendor, who arranges for non-emergency transportation services for Medicaid recipients.
- **Travel** Reimbursement for travel time is incorporated into the unit rate and may not be billed separately.

References

Agency for Health Care Administration. (2007). *Mental Health Targeted Case Management Coverage and Limitations Handbook*. Retrieved from:
https://ahca.myflorida.com/medicaid/review/specific_policy.shtml