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PREAMBLE

PRINCIPLES OF MEDICAL NECESSITY DETERMINATIONS

Magellan Complete Care has the belief that every enrollee is capable of recovery and resiliency. Magellan endeavors to promote care which is increasingly individualized, in which enrollees and their families are empowered to achieve their goals, and in which all enrollees maximize their opportunities to live full lives in their own communities.

Magellan’s care managers are available to assist enrollees and their families 24 hours/day and 365 days per year. Providing oversight and support to our care managers are our Care Management Center medical directors and our physician advisors: all Board-certified psychiatrists. This rich resource of psychiatric support allows enrollees to have access to professionals who are knowledgeable about evidence-based practices and are effective in making medical necessity determinations.

Magellan is committed to the philosophy of providing treatment at the most appropriate and least restrictive level of care necessary for effective and efficient treatment to meet the enrollee’s biopsychosocial needs. We see 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 levels of care as their changing clinical needs dictate. At any level of care, such treatment should be individualized and should take into consideration the enrollee’s stage of readiness to change and participate in treatment.

The Magellan Medical Necessity Criteria guide both providers and reviewers to the most appropriate level of care for an enrollee. While these criteria will assign the 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 other cases, clinical judgment consistent with the standards of good medical practice will be used in making medical necessity determinations.

Medical necessity decisions about each enrollee are based on the clinical information provided by the treating practitioner or facility, the application of the medical necessity criteria and available treatment resources. We recognize that a full array of services is not available everywhere. When a medically necessary level of care does not exist or is not available, we will authorize a higher than otherwise necessary level of care so that services are available that will meet the enrollee’s essential needs for effective treatment.

DEFINITION OF MEDICALLY NECESSARY

In accordance with 59G-1.010 (166) Florida Administrative Code, medically necessary means that:

1. 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; and
   - Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker, or the provider.

2. “Medically necessary” or “medical necessity” for hospital services requires that those services furnished on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished on an outpatient basis.

3. The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in and of itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
## I. HOSPITALIZATION, PSYCHIATRIC
### a. Adult

<table>
<thead>
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<th>Service Description and Common Service Settings</th>
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<tr>
<td><strong>Inpatient Services</strong> are intensive, twenty-four hour services, occurring in an appropriately licensed mental health facility. Services are provided under the supervision of a licensed psychiatrist and are focused on reducing immediate risk due to dangerousness to self or others, grave disability, or complicating medical conditions (coexisting with a mental health condition) that leave the enrollee at significant risk. Treatment is highly intensive, and is provided in a secure environment by a multidisciplinary team of qualified mental health professionals.</td>
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</tr>
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</table>

**Common Settings:**
- Inpatient Unit
- Crisis Stabilization Unit

**Service Definition:**
Hospitalization describes the highest level of skilled psychiatric services provided in a facility. This could be a free-standing psychiatric hospital, a psychiatric unit of general hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical

**Magellan - Setting and Admission Components**

This is the most intensive and restrictive level of care. It allows for interventions requiring a very high frequency of services, 24-hour professional monitoring, supervision and assistance. There is a very high degree of assurance of safety and security. There is availability and intensity of programs, which include more than once daily interventions requiring on-site professional and technical support.

Inpatient treatment also provides on-site medical and nursing services for enrollees at high risk of medical/surgical complications affecting or affected by psychiatric interventions or procedures.

**Admission Service Components (Must meet all of the following)**

1. Professional staff consisting of a multidisciplinary treatment team to include:
   - An attending psychiatrist, preferably Board certified;
   - Registered nurses;
   - Psychologists, social workers, educational specialists, or other mental health professionals and ancillary staff available when clinically indicated.

2. An Individualized, treatment plan which incorporates the enrollee's strengths and is directed toward

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### Admission Criteria

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

**I. Admission - Severity of Need**

Criteria 1, 2 and 3 and one of 4, 5, or 6 must be met to satisfy the criteria for severity of need.

1. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness (es) must be documented through the assignment of appropriate DSM-5 codes.

2. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

3. Due to the imminent risk or medical instability requiring admission, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is clearly indicated.

4. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
   - a current plan or intent to harm self with an available and lethal means, or
   - a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, or
   - an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, or
   - Other similarly clear and reasonable evidence of imminent serious harm to self.

5. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:
   - a current plan or intent to harm others with an available and lethal means, or
   - a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, or
   - violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, or
   - Other similarly clear and reasonable evidence of imminent serious harm to others.
and nursing care.
b. This definition also includes crisis beds that provide a similar, if not greater, intensity of medical and nursing care. For crisis programs, the psychiatric hospitalization criteria apply for medical necessity reviews.

<table>
<thead>
<tr>
<th>Common Service Settings</th>
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<tbody>
<tr>
<td></td>
<td>the alleviation of the impairment that caused the admission. This must be completed by the third day of inpatient care and is planned within the context of a highly structured program of care that is based upon a comprehensive assessment, including the possibility of substance abuse.</td>
<td>6. The patient’s condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient’s general medical or mental health.</td>
</tr>
</tbody>
</table>

II. Admission - Intensity and Quality of Service

Criteria 1, 2, 3, and 4 must be met to satisfy the criteria for intensity and quality of service.

1. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician no more than 24 hours prior to or 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

2. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.

3. If the patient is involved in treatment with another health provider then, with proper patient informed consent, this provider should be notified of the patient’s current status to ensure care is coordinated.

4. A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

Continued Stay Criteria

Criteria 1, 2, 3, 4, and 5 must be met to satisfy the criteria for continued stay.

1. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
   i. the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or
   ii. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation, or
5. Daily assessments and active interventions are completed by nurses or other mental health professionals, and physician services are provided daily frequently. All interventions and assessments are based upon the enrollee’s comprehensive treatment plan.
6. The enrollee and family, to the extent possible, are involved in treatment and discharge planning.

<table>
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<tr>
<td>iii. a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.</td>
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<tr>
<td>2. The current treatment plan includes documentation of DSM-5 diagnosis, individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with the patient’s family and/or other support systems, unless there is an identified, valid reason why it is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient’s post-hospitalization needs.</td>
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<td>3. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion 1. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.</td>
<td></td>
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<tr>
<td>4. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.</td>
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<tr>
<td>5. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.</td>
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</table>

**Exclusion Criteria:**
(Any of the following)

1. Enrollee does not have a covered DSM-5 code as a suspected diagnosis.
2. Enrollee does not require 24-hour professional monitoring, supervision and assistance.
3. Enrollee can be safely and feasibly treated at a less intensive and restrictive level of care.
4. Enrollee is seeking admission to inpatient treatment primarily for reasons other than medical necessity (e.g., to comply with a court-order, to obtain shelter, to deter runaway/truant behavior, to achieve family respite, etc.)
5. Enrollee is primarily suffering from a medical problem that requires inpatient treatment on a medical/surgical unit.

**Discharge Criteria**
(Must meet 1-3; or 4)

1. The symptoms/behaviors that precipitated admission have sufficiently improved so that the enrollee can be maintained at a less intensive and restrictive level of care and the enrollee will not be compromised with treatment being given at a less intensive and restrictive level of care.
2. A comprehensive discharge plan has been developed in consideration of the enrollee’s;
   a. strengths
   b. compliance with past treatment
   c. social and/or familial support system
<table>
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<td>d. resources and skills</td>
<td></td>
<td>e. identification of triggers for relapse; and other factors/obstacles to improvement, and</td>
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<td>e. identification of triggers for relapse; and other factors/obstacles to improvement, and</td>
<td></td>
<td>f. living arrangements (when needed).</td>
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<td></td>
<td>3. Arrangements for follow-up care have been made including a scheduled appointment within one week of discharge.</td>
</tr>
<tr>
<td>3. Arrangements for follow-up care have been made including a scheduled appointment within one week of discharge.</td>
<td></td>
<td>Or</td>
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<tr>
<td>4. Inpatient psychiatric treatment is discontinued because:</td>
<td></td>
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<tr>
<td>A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or</td>
<td></td>
<td>A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or</td>
</tr>
<tr>
<td>The enrollee withdraws from treatment against medical advice and does not meet criteria for involuntary commitment; or</td>
<td></td>
<td>The enrollee withdraws from treatment against medical advice and does not meet criteria for involuntary commitment; or</td>
</tr>
<tr>
<td>The enrollee is transferred to another facility/unit for continued inpatient care.</td>
<td></td>
<td>The enrollee is transferred to another facility/unit for continued inpatient care.</td>
</tr>
</tbody>
</table>
### Inpatient Services for children and adolescents

- Intensive, twenty-four hour services, occurring in an appropriately licensed mental health facility. Services are provided under the supervision of a licensed child and adolescent psychiatrist and are focused on reducing immediate risk due to dangerousness to self or others, grave disability, or complicating medical conditions (coexisting with a mental health condition) that leave the enrollee at significant risk. Treatment is highly intensive, and is provided in a secure environment by a multidisciplinary team of qualified mental health professionals.

<table>
<thead>
<tr>
<th>Common Settings:</th>
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</thead>
<tbody>
<tr>
<td>• Inpatient Unit</td>
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<tr>
<td>• Crisis Stabilization Unit</td>
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</table>

#### Service Definition: Hospitalization

- Hospitalization describes the highest level of skilled psychiatric services provided in a facility. This could be a free-standing psychiatric hospital, a psychiatric unit of general 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 that provide a similar, if not greater, intensity of medical care are licensed at the hospital level and provide 24-hour medical and nursing care.

<table>
<thead>
<tr>
<th>Magellan - Setting and Admission Components</th>
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</thead>
<tbody>
<tr>
<td>This is the most intensive and restrictive level of care. It allows for interventions requiring a very high frequency of services, 24-hour professional monitoring, supervision and assistance. It serves as an appropriate treatment setting for children and adolescents. There is a very high degree of assurance of safety and security. There is high availability and intensity of programs, which include more than once daily interventions requiring on-site professional and technical support.</td>
</tr>
</tbody>
</table>

- Inpatient treatment also provides on-site medical and nursing services for enrollees at high risk of medical/surgical complications affecting or affected by psychiatric interventions or procedures.

<table>
<thead>
<tr>
<th>Admission Service Components (Must meet all of the following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Professional staff consisting of a multidisciplinary treatment team to include:</td>
</tr>
<tr>
<td>- A child and adolescent psychiatrist; Board certification is strongly recommended;</td>
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<tr>
<td>- Registered nurses;</td>
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<tr>
<td>- Psychologists, social workers, educational specialists and other mental health professionals and ancillary staff available when clinically indicated.</td>
</tr>
<tr>
<td>2. An Individualized, treatment plan</td>
</tr>
</tbody>
</table>

### Admission Criteria

- The specified requirements for severity of need and intensity of service must be met to satisfy the criteria for admission.

#### I. Admission - Severity of Need

- **Criteria:** 1, 2, 3 and one of 4, 5 or 6 must be met to satisfy the criteria for severity of need.

1. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-5 codes.

2. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

3. Due to the imminent risk or medical instability requiring admission, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is clearly indicated.

4. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
   - a. a current plan or intent to harm self with an available and lethal means, or
   - b. a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, or
   - c. an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, or
   - d. other similarly clear and reasonable evidence of imminent serious harm to self.

5. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:
   - i. a current plan or intent to harm others with an available and lethal means, or
   - ii. a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, or
   - iii. violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, or
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<tr>
<td>and nursing care. For crisis programs, the psychiatric hospitalization criteria apply for medical necessity reviews.</td>
<td>which incorporates the enrollee’s strengths and is directed toward the alleviation of the impairment that caused the admission. This must be completed by the third day of inpatient care and is planned within the context of a highly structured program of care that is based upon a comprehensive assessment, including the possibility of substance abuse. Treatment is performed on a unit dedicated to child or adolescent populations whenever possible.</td>
<td>iv. other similarly clear and reasonable evidence of imminent serious harm to others.</td>
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<tr>
<td></td>
<td>3. Clinical interventions are consistent with enrollee’s risk of harm to self, others or property.</td>
<td>6. The patient’s condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient’s general medical or mental health.</td>
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<tr>
<td></td>
<td>4. Discharge planning must be initiated at time of admission</td>
<td>II. Admission - Intensity and Quality of Service</td>
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<tr>
<td></td>
<td>5. Availability of appropriate medical services.</td>
<td>Criteria 1, 2, 3, and 4 must be met to satisfy the criteria for intensity and quality of service.</td>
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<tr>
<td></td>
<td>6. Enrollee receiving psycho-educational assessment and services, if clinically indicated.</td>
<td>11. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician no more than 24 hours prior to or 24 hours following the admission. There must be the availability of an appropriate initial medical assessment, including a complete history of seizures and detection of substance abuse diagnosis and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.</td>
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<tr>
<td></td>
<td>7. Family system including parents/guardians and other caretakers receiving evaluation and intervention to the extent possible.</td>
<td>2. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.</td>
</tr>
<tr>
<td>Continued Stay Service Components (Must meet all of the following)</td>
<td>Continued Stay Criteria</td>
<td></td>
</tr>
<tr>
<td>1. The initial discharge plan has been formulated and is in the process of implementation.</td>
<td>Criteria 1, 2, 3, 4, and 5 must be met to satisfy the criteria for continued stay.</td>
<td></td>
</tr>
<tr>
<td>2. Active and timely treatment is focused upon stabilizing or reversing symptoms necessitating admission.</td>
<td>1. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:</td>
<td></td>
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<tr>
<td>3. Level of clinical intervention is consistent with current enrollee risk factors.</td>
<td>i. the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or</td>
<td></td>
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<td></td>
<td></td>
<td>ii. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or</td>
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<td>iii. that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. Subjective opinions without</td>
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<td>4. The treatment plan is frequently modified to reflect the enrollee’s progress and/or new information that has become available during the inpatient stay.</td>
<td>objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation, or</td>
<td>iv. a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.</td>
</tr>
<tr>
<td>5. Daily assessments and active interventions are completed by nurses or other mental health professionals and physician services are provided daily. All interventions and assessments are based upon the enrollee’s comprehensive treatment plan.</td>
<td>2. The current treatment plan includes documentation of DSM-5 diagnosis, individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system’s involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient’s post-hospitalization needs.</td>
<td>3. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion 1. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist or admitting qualified and credentialed professional.</td>
</tr>
<tr>
<td>6. Enrollee and family/parents/guardians/other caretakers, to the extent possible, are involved in treatment and discharge planning. There is intensive family involvement occurring several times per week (unless there is an identified valid reason why such a plan is not clinically appropriate or feasible).</td>
<td>4. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.</td>
<td>5. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.</td>
</tr>
</tbody>
</table>

**Exclusion Criteria:**
(Any of the following)

1. Enrollee does not have a DSM-5 code as a suspected diagnosis.
2. Enrollee does not require 24-hour professional monitoring, supervision and assistance.
3. Enrollee can be safely and feasibly treated at a less intensive and restrictive level of care.
4. Enrollee is seeking admission to inpatient treatment primarily for reasons other than medical necessity (e.g., to comply with a court-order, to obtain shelter, to deter runaway/truant behavior, to achieve family respite, etc.).
5. Enrollee is primarily suffering from a medical problem that requires inpatient treatment on a medical/surgical unit.

**Discharge Criteria**
(Must meet 1-3; or 4)

1. The symptoms/behaviors that precipitated admission have sufficiently improved so that the enrollee can be maintained at a less intensive and restrictive level of care and the enrollee will not be compromised with treatment being given at a less intensive and restrictive level of care.
2. A comprehensive discharge plan has been developed in consideration of the enrollee’s;
   a. strengths
   b. compliance with past treatment
   c. social and/or familial support system
   d. resources and skills
   e. identification of triggers for relapse; and other factors/obstacles to improvement, and
   f. living arrangements (when needed).

3. Arrangements for follow-up care have been made including a scheduled appointment within one week of discharge.

   Or

4. Inpatient psychiatric treatment is discontinued because:
   a. A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or
   b. The enrollee withdraws from treatment against medical advice and does not meet criteria for involuntary commitment; or
   c. The enrollee is transferred to another facility/unit for continued inpatient care.
## II. MEDICALLY-MONITORED INPATIENT DETOXIFICATION

### a. Adult

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| Inpatient Detoxification is a service involving sub acute care that is provided on an inpatient basis to assist individuals to withdraw from the physiological and psychological effects of substance abuse and who meet the placement criteria for this component. | - Prior Authorization is required  
- Service Limits: As applicable, 45 days/benefit year for adults, up to 365 days/benefit year for children <21 or pregnant women  
- Medical Necessity Criteria: ASAM Level 3.7 | **Admission Criteria:**  

The patient who is appropriately placed in a Level 3.7 program meets the diagnostic criteria for a moderate or severe substance use or addictive disorder, as defined in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association or the other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the patient’s presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by collateral parties (such as family members, legal guardians, and significant others).  

**NOTE:** Patients in Level 3.7 co-occurring capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a co-occurring capable program; or difficulties with mood, behavior, or cognition related to a substance use or mental disorder; or emotional, behavioral, or cognitive symptoms that interfere with overall functioning but not meet the DSM criteria for a mental disorder.

**Co-Occurring Enhanced Programs**  
The patient who is appropriately admitted to a Level 3.7 co-occurring enhanced program meets the diagnostic criteria for a mental disorder as well as a substance use or addictive disorder, as defined in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association or the other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the patient’s presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information obtained by collateral parties (such as family members, legal guardians, and significant others).

**ADULT DIMENSIONAL ADMISSION CRITERIA**  
The patient who is appropriately admitted to a Level 3.7 program meets specifications in at least two of the six dimensions, at least one of which is in Dimension 1, 2, or 3.

**DIMENSION 1:** Acute intoxication and/or Withdrawal Potential  

a. The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent. The severe withdrawal syndrome is assessed as manageable at this level of care.

**ALTERNATIVELY** to the above specifications:

b. There is a strong likelihood that the patient (who requires medication) will not complete withdrawal management at another level of care and enter into continuing treatment or self-help recovery, as evidenced (for example) by *any* of (1) or (2) or (3):

1. The patient requires medication and has a recent history of withdrawal management at a less intensive level of care, marked by past and current inability to complete withdrawal management and enter into continuing addiction treatment. The patient continues to have insufficient skills or supports to complete withdrawal management; or

2. The patient has a recent history of withdrawal management at less intensive levels of service that is marked by...
### Service Description and Common Service Settings

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<tr>
<td><strong>DIMENSION 1: Inability to Complete Withdrawal Management</strong></td>
<td>inability to complete withdrawal management or to enter into continuing addiction treatment, and he patient continues to have insufficient skills to complete withdrawal management; or</td>
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<tr>
<td>3. The patient has a comorbid physical, emotional, behavioral, or cognitive condition (such as chronic pain with active exacerbation or posttraumatic stress disorder with brief dissociative episodes) that is manageable in a level 3.7 WM setting but which increases the clinical severity of the withdrawal and complicates withdrawal management.</td>
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**DIMENSION 2: Biomedical Conditions and Complications**

The patient's status in Dimension 2 is characterized by one of the following:

- a. The interaction of the patient's biomedical condition and continued alcohol and/or other drug use places the patient at significant risk of serious damage to physical health or concomitant biomedical conditions (such as pregnancy with vaginal bleeding or ruptured membranes, unstable diabetes, etc.).

  *or*

- b. A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital.

**Biomedical Enhanced Services**

The patient who has a biomedical problem that requires a degree of staff attention (such as monitoring of medications or assistance with mobility) or staff intervention (such as changes in medication) that is not available in other Level 3.7 programs in need of biomedical enhanced services.

**DIMENSION 3: Emotional, Behavioral, or Cognitive Conditions, and Complications**

The patient who is appropriately admitted to a Level 3.7 program meets specifications in at least two of the six dimensions, at least one of which is in Dimension 1, 2, or 3.

Problems in Dimension 3 are not necessary for admission to a Level 3.7 program. However, if any of the Dimension 3 conditions are present, the patient must be admitting to a co-occurring capable or co-occurring enhanced program (depending on his or her level of function, stability, and degree of impairment).

**Co-Occurring Capable Programs**

The patient's status in Dimension 3 is characterized by at least one of the following:

- a. The patient’s psychiatric condition is unstable and presents with symptoms (which may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) that are interfering with abstinence, recovery, and stability to such a degree that the patient needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts;  
  *or*

- b. The patient exhibits stress behaviors associated with recent or threatened losses in work, family, or social domains; or there is a reemergence of feelings and memories of trauma and loss once the patient achieves abstinence, to a degree that his or her ability to manage the activities of daily living is significantly impaired. The patient thus requires a secure, medically monitored environment in which to address self-care problems (such as those associated with eating, sleeplessness, or personal hygiene) and to focus on his or her substance use or behavioral health problems;  
  *or*

- c. The patient has significant functional limitations that require active psychiatric monitoring. They may include—but are not limited to—problems with activities of daily living; problems with self-care, lethality, or dangerousness; and problems with
social functioning. These limitations may be complicated by problems in Dimensions 2 through 6;

or
d. The patient is at moderate risk of behaviors endangering self, others, or property, likely to result in imminent incarceration or loss of custody of children, and/or is in imminent danger of relapse (with dangerous emotional, behavioral, or cognitive consequences) without the 24-hour support and structure of a level 3.7 program;

 or
e. The patient is actively intoxicated, with resulting violent or disruptive behavior that poses imminent danger to self or others. Such a patient may, on further evaluation, belong in Level 4-WM withdrawal management or an acute observational setting if assessed as not safe in Level 3.7 service;

 or
f. The patient is psychiatrically unstable or has cognitive limitations that require stabilization but not medical management.

Co-Occurring Enhanced Programs
The patient's status in Dimension 3 is characterized by at least one of the following:
a. The patient has a history of moderate psychiatric decompensation (which may involve paranoia, moderate psychotic symptoms; or severe depressed mood, but not actively suicidal); or such symptoms occur during discontinuation of addictive drugs or when experiencing post-acute withdrawal symptoms, and such decompensation is present;

 or
b. The patient is assessed as at moderate to high risk of behaviors endangering self, others, or property, or is in imminent danger of relapse (with dangerous emotional, behavioral, or cognitive consequences) without 24-hour structure and support and medically monitored treatment. For example, without medically monitored inpatient treatment, the patient does not have sufficient coping skills to avoid harm to self, others, or property because of co-occurring mania;

 or
c. The patient is severely depressed, with suicidal urges and a plan. However, he or she is able to reach out for help as needed and does not require a one-on-one suicide watch;

 or
d. The patient has a co-occurring psychiatric disorder (such as anxiety, distractibility, or depression) that is interfering with his or her addiction treatment or ability to participate in a less intensive level of care, and thus requires stabilization with psychotropic medications;

 or

e. The patient has a co-occurring psychiatric disorder of moderate to high severity that is marginally and tenuously stable and requires care to prevent further decompensation. The patient thus requires co-occurring enhanced services and is best served in an addiction treatment program with integrated mental health services, or in a mental health program with integrated addiction treatment services.

DIMENSION 4: Readiness to Change
The patient's status in Dimension 4 is characterized by at least one of the following:
a. Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the patient does not accept or relate the addictive disorder to the severity of the presenting problem;

 or
b. The patient is in need of intensive motivating strategies, activities, and processes available only in a 24-hour structured, medically monitored setting;

 or
c. The patient needs ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program.

Co-Occurring Enhanced Programs
The patient's status in Dimension 4 is characterized by no commitment to change and no interest in engaging in activities necessary
to address a co-occurring psychiatric disorder. For example, the patient with bipolar disorder prefers his or her manic state over what feels like depression when stabilized, and thus does not adhere to a regimen of mood-stabilizing medications. Similarly, the patient is not consistently able to follow through with treatment, or demonstrates minimal awareness of a problem, or is unaware of the need to change behaviors related to behavioral or health problems. Such an individual requires active interventions with family, significant others, and/or other external systems to create leverage and align incentives so as to promote engagement in treatment, and is appropriately placed in a Level 3.7 co-occurring enhanced program.

**DIMENSION 5: Relapse, Continued Use, or Continued Problem Potential**

The patient's status in Dimension 5 is characterized by at least one of the following:

a. The patient is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his or her addictive or mental disorder (such as poor impulse control, drug seeking behavior, or increasing severity of anxiety or depressive symptoms). This situation poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support; or

b. The patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk to self or others in the absence of the type of 24-hour monitoring and structured support found in a medically monitored setting (for example, Driving Under the Influence (DUI), or not taking life-sustaining medications); or

c. The modality or intensity of treatment protocols to address relapse require that the patient receive care in a Level 3.7 program (such as initiating or restarting medications for medical or psychiatric conditions, an acute stress disorder, or the processing of a traumatic event) to safely and effectively initiate antagonist therapy (such as naltrexone for severe opioid use disorder), or agonist therapy (such as methadone or buprenorphine for severe opioid use disorder).

**Co-Occurring Enhanced Programs**

The patient's status in Dimension 5 is characterized by psychiatric symptoms that pose a moderate to high risk of relapse to a substance use or mental disorder. Such a patient demonstrates limited ability to apply relapse prevention skills, as well as demonstrating poor skills in coping with psychiatric disorders and/or avoiding or limiting relapse, with imminent serious consequences. The patient's follow through in treatment is limited or inconsistent, and his or her relapse problems are escalating to such a degree that treatment at a less intensive level of care is not succeeding or not feasible. For example, the patient continues to evidence self-harm behaviors or suicidal ideation or impulses with a plan to commit suicide, but agrees to reach out if seriously suicidal, and is assessed as capable of enough internal control to do so. Or the patient's continuing substance-induced mood states or psychotic symptoms are resolving, but his or her difficulties in remaining abstinent and craving for use are exacerbating his or her psychiatric symptoms.

**DIMENSION 6: Recovery Environment**

The patient's status in Dimension 6 is characterized by at least one of the following:

a. The patient requires continuous medical monitoring while addressing his or her substance use and/or psychiatric symptoms because his or her current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or active substance use, such that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care. For example, the patient is involved in an abusive relationship with an actively using significant other; or

b. Family members or significant others living with the patient are not supportive of his or her recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts. This situation requires structured treatment services and relief from the home environment in order for the patient to focus on recovery;
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<td></td>
<td>c. The patient is unable to cope, for even limited periods of time, outside of 24-hour care. The patient needs staff monitoring to learn to cope with Dimension 6 problems before he or she can be transferred safely to a less intensive setting.</td>
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<td><strong>Co-Occurring Enhanced Programs</strong></td>
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<tr>
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<td>The patient’s status in Dimension 6 is characterized by severe psychiatric symptoms. He or she may be too compromised to benefit from skills training to learn to cope with problems in the recovery environment. Such a patient requires planning for assertive community treatment, intensive care management, or other community outreach and support services. Such a patient’s living, working, social, and/or community environment is not supportive of addiction and/or psychiatric recovery. He or she has insufficient resources and skills to deal with this situation. For example, the patient may be unable to cope with a hostile family member with alcohol use disorder, and thus exhibits increasing anxiety and depression. Such a patient needs the support and structure of a Level 3.7 co-occurring enhanced program to achieve stabilization and prevent further decompensation.</td>
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<td><strong>Continued Stay:</strong></td>
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<td>The patient continues to meet admission criteria. As the patient moves through treatment in any level of service, his or her progress in all six dimensions should be formally assessed at regular intervals relevant to the patient’s severity of illness and level of function, and the intensity of service and level of care. For acute care settings, the instability and rapid changes may necessitate reviewing the treatment daily.</td>
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### Inpatient Service Settings

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<tr>
<td>Inpatient Detoxification is a service involving sub acute care that is provided on an inpatient basis to assist individuals to withdraw from the physiological and psychological effects of substance abuse and who meet the placement criteria for this component.</td>
<td><strong>Prior Authorization is required</strong></td>
<td><strong>ADOLESCENT DIAGNOSTIC ADMISSION CRITERIA</strong></td>
</tr>
<tr>
<td><strong>Common Settings:</strong></td>
<td><strong>Service Limits: up to 365 days/benefit year for children &lt;21</strong></td>
<td>The adolescent who is appropriately placed in a Level 3.7 program meets the diagnostic criteria for a moderate or severe substance use or addictive disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standarized and widely accepted criteria, as well as the dimensional criteria for admission.</td>
</tr>
<tr>
<td>Free standing detox unit</td>
<td><strong>Medical Necessity Criteria: ASAM Level 3.7</strong></td>
<td>If the adolescent’s presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by collateral parties (such as family members, legal guardians, and significant others).</td>
</tr>
<tr>
<td>Inpatient Unit</td>
<td>Substance abuse rehabilitation (other than for pregnant women), including court ordered services, are not covered in the inpatient setting.</td>
<td>The adolescent who is appropriately admitted to a Level 3.7 program meets specifications in two of the six dimensions, at least one of which is in Dimension 1, 2, or 3.</td>
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### Adolescent

**ADOLESCENT DIAGNOSTIC ADMISSION CRITERIA**

The adolescent who is appropriately placed in a Level 3.7 program meets the diagnostic criteria for a moderate or severe substance use or addictive disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standarized and widely accepted criteria, as well as the dimensional criteria for admission.

If the adolescent’s presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by collateral parties (such as family members, legal guardians, and significant others).

The adolescent who is appropriately admitted to a Level 3.7 program meets specifications in two of the six dimensions, at least one of which is in Dimension 1, 2, or 3.

**DIMENSION 1: Acute Intoxication and/or Withdrawal Potential**

The adolescent’s status in Dimension 1 is characterized by the following:

- The adolescent is experiencing or at risk of acute or sub acute intoxication or withdrawal, with moderate to severe signs and symptoms. He or she needs 24-hour treatment services, including the availability of active medical and nursing monitoring to manage withdrawal, support engagement in treatment, and prevent immediate continued use. Alternatively, the adolescent has a history of failure in treatment at the same or a less intensive level of care.

Problems with intoxication or withdrawal are manageable at this level of care.

Withdrawal rating scale tables and flow sheets (which may include the tabulation of vital signs) are used as needed.

Drug –specific examples follow:

a. **Alcohol**: Moderate withdrawal, with significant symptoms that require access to nursing and medical monitoring. The patient may have a history of daily drinking or drinking to self-medicate withdrawal, or regular morning drinking. He or she may require sedative/hypnotic substitution therapy, but typically this can be managed with a standing taper without the need for extensive titration.

b. **Sedative/hypnotics**: Moderate withdrawal, with significant symptoms that require access to nursing and medical monitoring. The adolescent may be cross-dependent on other substances and may require withdrawal management with tapering substitute agonist therapy and/or pharmacological management of symptoms.

c. **Opiates**: Moderate to severe withdrawal, usually in the context of daily opiate use. The patient requires access to nursing and medical monitoring, may require use of prescription medications or agonist substitution therapy, and may need monitoring for induction of antagonist therapy (as with naltrexone). Severe craving states or affective instability typical of withdrawal may require high-intensity 24-hour treatment to support engagement.

d. **Stimulants**: Severe withdrawal (involving sustained affective or behavioral disturbances or mild psychiatric symptoms), which requires access to nursing and medical monitoring. Severe craving states or affective instability typical of withdrawal may require high-intensity 24-hour treatment to support engagement.

e. **Inhalants**: Severe sub acute intoxication (involving mild delirium or other serious cognitive impairment, lethargy, agitation, and depression) of sufficient intensity that the patient requires access to nursing and medical monitoring.

f. **Marijuana**: Severe sustained intoxication (involving mild psychosis, coarse cognitive disorganization, agitation, and the like), which requires access to nursing and medical monitoring.

g. **Hallucinogens**: Severe chronic intoxication (involving mild delirium, mild psychosis, agitation, moderate to severe affective instability, cognitive disorganization, and the like), which requires access to nursing and medical monitoring.
DIMENSION 2: Biomedical Conditions and Complications

The adolescent’s status in Dimension 2 is characterized by one of the following:

a. The interaction of the adolescent’s biomedical condition and continued alcohol and/or other drug use places the adolescent at significant risk of serious damage to physical health or concomitant biomedical (such as pregnancy with vaginal bleeding or ruptured membranes, unstable diabetes or asthma, etc) or

b. A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital.

Biomedical Enhanced Services

The adolescent who has a biomedical problem that requires a degree of staff attention (such as monitoring of medications or assistance with mobility) or staff intervention (such as changes in medication) that is not available in other Level 3.7 programs is in need of biomedical enhanced services.

DIMENSION 3: Emotional, Behavioral, or Cognitive Conditions and Complications

The adolescent’s status in Dimension 3 is characterized by one of the following (requiring 24-hour supervision and a high-intensity therapeutic milieu, with access to nursing and medical monitoring treatment):

a. Dangerousness/Lethality: The adolescent is at moderate risk (and possibly unpredictable) risk of imminent harm to self or others and needs 24-hour monitoring and/or treatment in a high-intensity programmatic milieu and/or enforced secure placement for safety.

b. Interference with Addiction Recovery Efforts: The adolescent’s recovery efforts are negatively affected by his or her emotional, behavioral, or cognitive problems in significant and distracting ways. He or she requires 24-hour structured therapy and/or a high-intensity programmatic milieu to stabilize unstable emotional or behavioral problems (as through ongoing medical or nursing evaluation, behavior modification, titration of medications, and the like).

c. Social Functioning: The adolescent has significant impairments, with severe symptoms (such as poor impulse control, disorganization, and the like), which seriously impairs his or her ability to function in family, school, or work settings and which cannot be managed at a less intensive level of care. These might involve a recent history of aggressive or severely disruptive behavior, severe inability to manage peer conflict, a recurrent or chronic pattern of runaway behavior requiring enforced confinement, and the like.

d. Ability for Self-Care: The adolescent has a significant lack of personal resources and moderate to severe impairment in ability to manage the activities of daily living. He or she needs 24-hour supervision and significant staff assistance, including access to nursing or medical services. The adolescent’s impairments may involve progressive and severe dilapidation and self-neglect in the context of advances substance use disorder, the need for observation after eating to prevent self-induced vomiting, the need for intensive reinforcement of medication adherence, the need for intensive modeling of adequate self-care during pregnancy, the need for intensive training for self-care during pregnancy, the need for intensive training for self-care in a cognitively impaired patient, and the like.

e. Course of Illness: The adolescent’s history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without 24-hour supervision and a high-intensity programmatic milieu, with access to nursing or medical monitoring or treatment. These may be required to treat an adolescent who, for example, requires secure placement or enforced abstinence for reinstatement or titration of a pharmacological treatment regimen; or an adolescent whose substance use has been associated with a dangerous pattern of aggressive/violent behaviors and who needs monitoring to assess safety and likelihood of outpatient treatment success before returning to the community following release from a juvenile justice setting; or an adolescent who requires intensive monitoring or treatment because ongoing substance use prevents monitoring.
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<td>adequate or safe treatment or diagnostic clarification for an emotional, behavioral, or cognitive condition that may or may not be substance-induced; or an adolescent whose history suggests rapid escalation of dangerousness/lethality when using alcohol or drugs and who is in relapse or at imminent risk of relapse.</td>
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**DIMENSION 4: Readiness to Change**

The adolescent’s status in Dimension 4 is characterized by at least one of the following:

a. Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the adolescent does not accept or relate the addictive disorder to the severity of the presenting problem;
   or
b. The adolescent is in need of intensive motivating strategies, activities, and processes available only in a 24-hour structured, medically monitored setting;
   or
c. The adolescent needs ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program.

**DIMENSION 5: Relapse, Continued Use, or Continued Problem Potential**

The adolescent’s status in Dimension 5 is characterized by at least one of the following:

a. The adolescent is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his or her addictive or mental disorder (such as poor impulse control, drug seeking behavior, or increasing severity of anxiety or depressive symptoms). This situation poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support;
   or
b. The adolescent is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk of harm to self or others in the absence of 24-hour monitoring and structured support found in a medically monitored setting (for example, not taking life-sustaining medications; or the adolescent has severe and chronic problems with impulse control that requires stabilization through high-intensity medical and nursing interventions; or he or she has issues with intoxication or withdrawal that require stabilization in a medically monitored setting; or there is a likelihood of self-medication of recurrent symptoms of a mood disorder, which require stabilization in a medically monitored setting). Treatment at a less intensive level of care has been attempted or given serious consideration.
   or
c. The modality or intensity of treatment protocols to address relapse require that the patient receive care in a Level 3.7 program (such as initiating or restarting medications for medical or psychiatric conditions, an acute stress disorder, or the processing of a traumatic event) to safely and effectively initiate antagonist therapy (such as naltrexone for severe opioid use disorder), or agonist therapy (such as methadone or buprenorphine for severe opioid use disorder).

**DIMENSION 6: Recovery Environment**

The adolescent’s status in Dimension 6 is characterized by at least one of the following:

a. The adolescent has been living in an environment in which supports that might otherwise have enabled treatment at a less intensive level of care are unavailable. For example, the family undermines the
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<tr>
<td>adolescent’s treatment, or is unable to sustain treatment attendance at a less intensive level of care, or family members have active substance use disorders and or facilitate and/or facilitate access to alcohol or other drugs, or the home environment is dangerously chaotic or abusive, or the family is unable to adequately supervise medications, or the family is unable to adequately implement a needed behavior management plan. Level 3.7 care thus is needed to effect a change in the home environment so as to establish a successful transition to a less intensive level of care.</td>
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<tr>
<td>b. Logistical impediments (such as distance from a treatment facility, mobility limitations, lack of transportation, and the like) preclude participation in treatment at a less intensive level of care, and Level 3.7 care is necessary to establish a successful transition to a less intensive level of care.</td>
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**Continued Stay:**

The patient continues to meet admission criteria. As the patient moves through treatment in any level of service, his or her progress in all six dimensions should be formally assessed at regular intervals relevant to the patient’s severity of illness and level of function, and the intensity of service and level of care. For acute care settings, the instability and rapid changes may necessitate reviewing the treatment daily.
### III. 23-HOUR OBSERVATION

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<td>The main objective of 23-hour observation is to promptly evaluate and stabilize individuals presenting in a crisis situation. This level of care provides up to 23 hours and 59 minutes 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.</td>
<td>1. 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.</td>
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<tr>
<td>Common Settings:</td>
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<tr>
<td>- Inpatient Unit</td>
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<td>- Crisis Stabilization Unit</td>
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#### Admission Criteria

**Criteria for Admission**

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

**I. Admission - Severity of Need**

Criteria 1, 2, 3, and 4 must be met to satisfy the criteria for severity of need.

1. The patient has a diagnosed or suspected psychiatric and/or substance use disorder. A psychiatric and/or substance use disorder is defined as a disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-5. There may be a lack of a primary definitive DSM-5 diagnosis and/or an incomplete understanding of the patient’s clinical needs due to a lack of clinical information or an evolving clinical condition (e.g., intoxication) in which an extended observation period is medically necessary in order to establish a primary, definitive DSM-5 and subsequent treatment plan.

2. Based on the potential risk to self or others, the patient requires an individual plan of extended observation, acute medical and therapeutic crisis intervention and continuity of care services in a facility setting with medical staffing, psychiatric supervision and continuing nursing evaluation. The 23-hour observation must provide immediate services in a facility setting that may include, but are not limited to, diagnostic clarification, assessment of needs, medication monitoring and administration, individual therapy, family and/or other support system involvement, and suicidal/homicidal observation and precautions as needed.

3. Although there is evidence of a potential or current mental health or substance abuse emergency based on history or initial clinical presentation, the need for confinement beyond 23 hours and 59 minutes, this level of care would not be appropriate.

4. The patient must be medically stable, or there must be appropriate medical services to monitor and treat any active medical condition.

**II. Admission - Intensity and Quality of Service**

Criteria 1, 2, 3, 4, 5, and 6 must be met to satisfy the criteria for intensity and quality of service.

1. Acute care nursing, medication management and monitoring are available, and all appropriate drug screens, laboratory studies, and medical testing are considered in accordance with accepted medical practice and clinical practice guidelines.

2. A comprehensive evaluation, administered by a psychiatrist, which includes a biopsychosocial assessment (based on the available information), mental status examination, and physical examination is completed and appropriate treatment and disposition recommendations are formulated with intent to execute/implement.

3. Clinical interventions emphasize crisis intervention, relapse prevention and motivational strategies with the intent to stabilize the patient and enhance motivation for change utilizing medication management, individual therapy and/or family or other support system involvement (the frequency of which will be determined by what the treatment team believes is needed to stabilize and re-evaluate the patient) with focus on proximal events in a brief solution-focused model.
4. Consultation services are available for general medical, pharmacology and psychological services.  
5. Outpatient treatment providers and/or primary care physicians are consulted during the observation period as clinically indicated (and with the patient's documented consent). 
6. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in the admission to a 23-hour observation bed, and this discharge plan begins to identify appropriate treatment resources following discharge. Reasonable attempts are made to coordinate the treatment and affect a timely disposition plan in collaboration with current treatment providers.

**Continued Stay Criteria**

None

**Discharge Criteria**

Criteria 1 or 2 must be met to satisfy criteria for discharge:

1. The patient meets admission criteria for inpatient hospitalization. 
2. The patient no longer meets admission criteria and can be safely and effectively treated at a less-intensive and restrictive level of care.
IV. STATEWIDE INPATIENT PSYCHIATRIC PROGRAM (SIPP)

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| Statewide Inpatient Psychiatric Programs (SIPP): provide intensive psychiatric services to children in a locked residential setting and are designed to serve those high-risk youths that fail to benefit from acute inpatient or traditional outpatient treatment settings. | 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 (Must meet all of the following)  
- There are no emergency admissions into a SIPP. 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 Medicaid Administration and the provider.  
  - The child or adolescent has age-appropriate cognitive ability.  
  - The enrollee’s family or legal guardian must be contacted by the physician advisor or other designee to obtain admission approval. 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 admission. | Admission Criteria (Must meet all criteria : 1,2, 3, 4, and 5):  
1. All admissions are non-emergency and voluntary.  
2. Medical clearance must be given by a physician prior to admission.  
3. The child or adolescent has age appropriate cognitive ability to benefit from treatment.  
4. The child or adolescent has the cognitive and developmental ability to benefit from 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:  
   1. A lower level of care will not meet the enrollee’s treatment needs. Examples of lower levels of care include  
      a. Family or relative placement with outpatient therapy;  
      b. Day or after-school treatment;  
      c. Foster care with outpatient therapy;  
      d. Therapeutic foster care;  
      e. Group childcare supported by outpatient therapy;  
      f. Therapeutic group childcare;  
      g. Partial hospitalization; and  
      h. Custodial care.  
   2. 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:  
   1. A DSM-5 diagnoses is present and has been established through a documented comprehensive |
### 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 7 days prior to the enrollee’s last certified day to request additional certification.

### Estimated Length of Stay and Discharge Planning:

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.

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<td>those children not “dependent.”</td>
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<td>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 abuse disorder may be present.</td>
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</table>

2. The enrollee is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as a, b, c, or d:

- **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 longstanding enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications).

- **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:
  1. Severely depressed mood
  2. Recent loss
  3. Recent suicide attempt or gesture or past history of multiple attempts or gestures
  4. Concomitant substance abuse
  5. Recent suicide or history of multiple suicides in family or peer group

- **Impaired Thought and/or Perceptual Processes (Reality Testing):** Inability to perceive and validate reality to the extent that the patient 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:**
  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. Not responsive to outpatient trial of medication or supportive care
  4. Requires sub-acute diagnostic evaluation to determine treatment needs
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<td>d. <strong>Severely Dysfunctional Patterns:</strong> Family, environmental, or behavioral processes that place the enrollee at risk</td>
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**Indicators (one of the following):**

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

3. 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.

4. 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 abuse 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)).

1. The treating facility shall provide a description of the plan for treatment illustrating the required services available at a SIPP level of care.
2. 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.

3. 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
      
      a. Family or relative placement with outpatient therapy;
      b. Day or after-school treatment;
      c. Foster care with outpatient therapy;
      d. Therapeutic foster care;
      e. Group childcare supported by outpatient therapy;
      f. Therapeutic group childcare;
      g. Partial hospitalization; and
      h. 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 patient continues to have a psychiatric condition or disorder that is classified as a DSM-5 diagnosis. A concurrent Axis I substance abuse disorder may be present.

   B. The enrollee continues to experience problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as (a), (b), (c), and (d):

   a. **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.

b. **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

c. **Impaired Thought and/or Perceptual Processes (Reality Testing)**: Inability to perceive and validate reality to the extent that the patient 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

d. **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 abuse).

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

a. Deficits in cognition, control, or judgment due to diagnosis;

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.

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

- 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 (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: (All of the following shall be met):**

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 Abuse 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.

**Note:** In order to provide for continuity of care for the child, the SIPP request for proposal (RFP) 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.

**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 abuse, mental retardation, or autism
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<td>3. The enrollee is not expected to benefit from this level of treatment</td>
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<td>4. The presenting problem is not psychiatric in nature and will not respond to psychiatric treatment</td>
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<td>5. The youth has a history of long-standing violations of the rights and property of others</td>
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<td>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</td>
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<td>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</td>
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<td>8. Lack of medical clearance from a physician for admission</td>
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V. SUBSTANCE ABUSE INTENSIVE OUTPATIENT PROGRAM (SA IOP- H0015)

a. Adult

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</table>
| Intensive Outpatient Programs (ASAM Level 2.1, IOP) provide nine or more hours per week of highly structured outpatient therapy and education to address substance abuse and mental health problems. The need for IOP services must be determined by a comprehensive biopsychosocial assessment in consultation with the client. Medical/psychiatric consultation, medication management and other support services may be needed. Such services may include individual and group counseling, medication management and family therapy. An IOP program should address a wide range of issues including, but not limited to: relapse prevention, models of addiction, triggers, managing emotions, physical effects of alcohol and other drugs, the interference of addiction with parenting, spirituality, medical aspects of addiction, stages of change, thinking errors, and other factors that influence life functioning due to the presence of addictive behaviors. | - Expanded benefit  
- Prior Authorization is required  
- Service Limits: Unlimited based on MNC. Authorization issued for a max of 6 days of service. Prior authorization is needed for continued stay.  
- Medical Necessity Criteria: ASAM Level 2.1 Frequency of services:  
  - Group treatments may occur three times, or more, weekly depending on the need of the client. Individual treatment is frequently a supplement to group therapy and Family Therapy may be included.  
  - 9 hours/week for Adults | Admission Criteria:  
Admission to a level 2.1 program is advisable for the patient who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) AND in Dimension 3 (if any emotional, behavioral, or cognitive conditions or problems exist), as well as in at least one of Dimensions 4, 5, or 6.  

Dimension 1: Acute Intoxication and/or Withdrawal Potential  
The patient has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a level 2.1 setting.  

Dimension 2: Biomedical Conditions and Complications  
In dimension 2, the patient’s biomedical conditions and problems, if any, are stable or are being addressed concurrently and thus will not interfere with treatment. Examples include mild pregnancy-related symptoms, asthma, hypertension, or diabetes.  

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications  
Problems in Dimension 3 are not necessary for admission to a Level 2.1 (Intensive outpatient) program. However, if any of the Dimension 3 conditions are present, the client must be admitted to either a co-occurring Capable or co-occurring Enhanced program, depending on the client’s level of function, stability and degree of impairment in this dimension.  

Co-occurring Capable Programs  
The client’s status in Dimension 3 is characterized by (a) or (b):  
a. The patient engages in abuse of family members or significant others, and requires intensive outpatient treatment to reduce the risk of further deterioration; or  
b. The client has a diagnosed emotional, behavioral or cognitive disorder that requires intensive outpatient monitoring to minimize distractions from their treatment or recovery.  

Co-occurring Enhanced Programs  
The client’s status in Dimension 3 is characterized by (a) or (b) or (c):  
a. The client has a diagnosed emotional, behavioral or cognitive disorder that requires management because the patient’s history suggests a high potential for distraction him or her from treatment; such a disorder requires stabilization concurrent with addiction treatment (for example, an unstable borderline personality disorder, compulsive personality disorder, unstable anxiety, or mood disorder; or  
b. The patient is assessed as at mild risk of behaviors endangering self, others or property (for example, he or she has a suicidal or homicidal thoughts but no active plan); or  
c. The patient is at significant risk of victimization by another. However, the risk is not severe enough to require 24-hour supervision (for example, the patient has sufficient coping skills to maintain safety through attendance at treatment sessions at least 9 or more hours per week).  

Dimension 4: Readiness to Change  
The patient’s status in Dimension 4 is characterized by (a) or (b):  
a. The patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed. Such interventions are not feasible or are not likely to succeed in a Level 1 program; or  

- 30 -
b. The patient’s perspective inhibits his or her ability to make behavior changes without repeated, structured, clinically directed motivational interventions. (For example, the patient attributes his or her alcohol or other drug and mental health problems to other persons or external events rather than to an addictive or mental disorder.) Such interventions are not feasible or not likely to succeed in a level 1 program. However, the patient’s willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest that treatment at level 2.1 can be effective.

Co-occurring Enhanced Programs
The patient’s status in Dimension 4 is characterized by meeting criteria for all programs and (a); and one of (b) or (c): 

a. The patient is reluctant to agree to treatment and is ambivalent about his or her commitment to change a co-occurring mental health problem; or

b. The patient is assessed as requiring intensive services to improve his or her awareness of the need to change. The patient has such limited awareness of or commitment to change that he or she cannot maintain an adequate level of functioning without Level 2.1 services. For example, the patient continues to experience mild to moderate depression, anxiety, or mood swings, and is inconsistent in taking medication, keeping appointments, and completing mental health assignments; or

c. The patient’s follow through in treatment is so poor or inconsistent that Level 1 services are not succeeding or are not feasible.

Dimension 5: Relapse, Continued Use, or Continued Problem Potential
The patient’s status in Dimension 5 is characterized by (a) or (b)

a. Although the patient has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms of the substance-related disorder (such as difficulty postponing immediate gratification and related drug-seeking behavior) and his or her level of functioning is deteriorating despite modification of the treatment plan; or

b. There is a high likelihood that the patient will continue to use or relapse to use of alcohol and/or other drugs or gambling without close outpatient monitoring and structured therapeutic services, as indicated his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment. The patient has unsuccessfully attempted treatment at a less intensive level of care, or such treatment is adjudged insufficient to stabilize the patient’s condition so that direct admission to level 2.1 is indicated.

Co-Occurring Enhanced Programs
The patient’s status in Dimension 5 is characterized by psychiatric symptoms that pose a moderate risk of relapse to the alcohol, other drug or other addictive or psychiatric disorder.

Such a patient has impaired recognition or understanding of- and difficulty in managing relapse issues and requires Level 2.1 (Intensive Outpatient) Co-Occurring Enhanced Program services to maintain and adequate level of functioning. For example, the patient may have chronic difficulty in controlling his or her anger, with impulses to damage property, or the patient continues to increase his or her medication dose beyond the prescribed level in an attempt to control continued symptoms of anxiety or panic.

Dimension 6: Recovery Environment
The patient’s status in Dimension 6 is characterized by (a) or (b):

a. Continued exposure to the patient’s current school, work or living environment will render recovery unlikely. The patient lacks resources or skills needed to maintain an adequate level of functioning without the services of a level 2.1 program;

b. The patient lacks social contacts, or has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He or she also lacks the resources or skills to maintain an adequate level of functioning without level 2.1 services.
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<td>Co-Occurring Enhanced Programs</td>
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<td>The patient’s status in Dimension 6 is characterized by a living, working, social and/or community environment that is not supportive of good mental functioning. The patient has insufficient resources and skills to deal with this situation. For example, the patient is unable to cope with continuing stresses caused by hostile family members with addiction, and he or she evidences increasing depression and anxiety. The support and structure of a level 2.1 co-occurring enhanced program provide sufficient stability to prevent further deterioration.</td>
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<td>Continued Stay</td>
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<td>The patient continues to meet admission criteria. As the patient moves through treatment in any level of service, his or her progress in all six dimensions should be formally assessed at regular intervals relevant to the patient’s severity of illness and level of function, and the intensity of service and level of care.</td>
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## b. Adolescent

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<tr>
<th>Intensive Outpatient Programs (ASAM Level 2.1, IOP) provide nine or more hours per week of highly structured outpatient therapy and education to address substance abuse and mental health problems. The need for IOP services must be determined by a comprehensive biopsychosocial assessment in consultation with the client. Medical/psychiatric consultation, medication management and other support services may be needed. Such services may include individual and group counseling, medication management and family therapy. An IOP program should address a wide range of issues including, but not limited to: relapse prevention, models of addiction, triggers, managing emotions, physical effects of alcohol and other drugs, the interference of addiction with parenting, spirituality, medical aspects of addiction, stages of change, thinking errors, and other factors that influence life functioning due to the presence of addictive behaviors.</th>
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<tr>
<td><strong>Admission Criteria:</strong></td>
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<td>The adolescent who is appropriately placed in a level 2.1 program (IOP) is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the America Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.</td>
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<tr>
<td>If the adolescent's presenting alcohol and/or other drug use and other addictive behavior history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).</td>
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<tr>
<td>Direct admission to a level 2.1 program is advisable for the adolescent who meets the stability specifications in Dimension 1 (if any withdrawal problems exist) and Dimension 2 (if any biomedical conditions or problems exist) and the severity specification in at least one of Dimensions 3, 4, 5, or 6.</td>
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<tr>
<td>Transfer to a Level 2.1 program is appropriate for the adolescent who has met the objectives of treatment in a more intensive level of care and who requires the intensity of service provided at Level 2.1 in at least one dimension.</td>
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<td>An adolescent also may be transferred to a Level 2.1 from a Level 1 program when the services provided at that level have proven insufficient to address his or her needs or when Level 1 services have consisted of motivational interventions to prepare the adolescent for participation in a more intensive level of care for which he or she now meets criteria. (The adolescent may be transferred to the next higher intensity level of care if the indicated level is not available in the immediate geographic area.)</td>
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### Dimension 1: Acute Intoxication and/or Withdrawal Potential

The adolescent who is appropriately placed in a level 2.1 program is not experiencing or at risk of acute withdrawal. At most, the adolescent’s symptoms consist of sub acute withdrawal marked by minimal symptoms that are diminishing (as during the first several weeks of abstinence following a period of more severe acute withdrawal). The adolescent is likely to attend, engage, and participate in treatment, as evidenced by his or her meeting the following criteria:

- a. The adolescent is able to tolerate mild sub acute withdrawal symptoms.
- b. He or she has made a commitment to sustain treatment and to follow treatment recommendations.
- c. The adolescent has external supports (family and/or court) that promote engagement in treatment.

### Note:

If the adolescent presents for treatment after recently experiencing an episode of acute withdrawal without treatment (as opposed to stepping down from a more intensive level of care following a good response), it is safer to err on the side of greater intensity of services when making a placement decision.

### Dimension 2: Biomedical Conditions and Complications

In dimension 2, the adolescent’s biomedical conditions and problems are severe enough to distract from recovery and treatment at a less intensive level of care, but will not interfere with recovery at Level 2.1. The biomedical conditions and problems are being addressed concurrently by a medical treatment provider.

### Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications
The adolescent’s status in Dimension 3 is characterized by at least one of the following:

**a. Dangerousness/Lethality:** The adolescent is at mild risk of behaviors endangering self, others or property (for example, he or she has suicidal or homicidal thoughts, but no active plan), and requires frequent monitoring to assure that there is a reasonable likelihood of safety between IOP sessions. However, his or her condition is not so severe as to require daily supervision.

**b. Interference with Addiction Recovery Efforts:** The adolescent’s recovery efforts are negatively affected by an emotional, behavioral or cognitive problem, which causes mild interference with and requires increased intensity to support treatment participation and/or adherence. For example, the adolescent requires frequent repetition of treatment materials because of memory impairment associated with marijuana use.

**c. Social Functioning:** The adolescent’s symptoms are causing mild to moderate difficulty in social functioning (involving friends, but not to such a degree that he or she is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work or community. For example, the adolescent’s problems may involve significantly worsening school performance or in school detentions, a circle of friends that has narrowed to predominantly drug users, or loss of interest in most activities other than drug use.

**d. Ability for Self-Care:** The adolescent is experiencing mild to moderate impairment in ability to manage the activities of daily living, and thus requires frequent monitoring and treatment interventions. Problems may involve poor hygiene secondary to exacerbation of a chronic mental illness, poor self-care or lack of independent living skills in an older client who is transitioning to adulthood, or in a younger adolescent who lacks adequate family supports.

**e. Course of Illness:** The adolescent’s history and present situation suggest that an emotional, behavioral or cognitive condition would become unstable without frequent monitoring and maintenance. For example, he or she may require frequent prompting and monitoring of medication adherence (in an adolescent with a history of medication non adherence) or frequent prompting and monitoring of behavioral adherence (in an adolescent with a conduct disorder or other serious pattern of delinquent behavior).

**Dimension 4: Readiness to Change**

The adolescent’s status in Dimension 4 is characterized by (a) or (b):

- a. The adolescent requires structured therapy and a programmatic milieu to promote progress through the stages of change, as evidenced by behaviors such as the following: (1) the adolescent is verbally compliant, but does not demonstrate consistent behaviors; (2) the adolescent is only passively involved in treatment; or (3) the adolescent demonstrates variable adherence with attendance at outpatient sessions or self or mutual help meetings or support groups. Such interventions are not feasible or are not likely to succeed in a Level 1 service;

  or

- b. The adolescent’s perspective inhibits his or her ability to make progress through the stages of change. For example, he or she has unrealistic expectations that the alcohol or other drug problem will resolve quickly and with little or no effort, or does not recognize the need for continued assistance. The adolescent thus requires structured therapy and a programmatic milieu. Such interventions are not feasible or are not likely to succeed in a Level 1 service.

**Dimension 5: Relapse, Continued Use, or Continued Problem Potential**

The adolescent’s status in Dimension 5 is characterized by (a) or (b):

- a. Although the adolescent has been an active participant at a less intensive level of care, he or she is experiencing an intensification of symptoms of the substance-related disorder (such as difficulty postponing immediate gratification and related drug-seeking behavior) and his or her level of functioning is deteriorating despite modification of the treatment plan:
### Dimension 6: Recovery Environment

The adolescent’s status in Dimension 6 is characterized by (a) **or** (b) **or** (c):

a. Continued exposure to the adolescent’s current school, work, or living environment will render recovery unlikely. The adolescent lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.1 program; **or**

b. The adolescent lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. He or she also lacks the resources or skills necessary to maintain an adequate level of functioning without Level 2.1 services; **or**

c. In addition to the characteristics for all programs, a third option is that the adolescent’s family or caretaker are supportive of recovery, but family conflicts and related family dysfunction impede the adolescent’s ability to learn the skills necessary to achieve and maintain abstinence.

**NOTE:** The adolescent may require Level 2.1 services in addition to an out-of-home placement (for example, at Level 3.1 or the equivalent, such as a group home or a non-treatment residential setting such as a detention program). If his or her present environment is supportive of recovery but does not provide sufficient addiction-specific services to foster and sustain recovery goals, the adolescent’s needs in Dimension 6 may be met through an out-of-home placement, while other dimensional criteria would indicate the need for care in a Level 2.1 program.

### Continued Stay

The patient continues to meet admission criteria. As the patient moves through treatment in any level of service, his or her progress in all six dimensions should be formally assessed at regular intervals relevant to the patient’s severity of illness and level of function, and the intensity of service and level of care.
**VI. OUTPATIENT ELECTROCONVULSIVE THERAPY (ECT) (90870)**

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| **Psychiatric Electroconvulsive Therapy (ECT).** ECT (or Electroshock Therapy) is an established form of treatment for a variety of mental conditions particularly Major Depression, Bipolar Depression, and Schizophrenia. ECT needs to be conducted in a fully-equipped medical facility with full emergency medical capability to manage any complications of the ECT. The procedure needs to be directed by a Board-certified psychiatrist who is qualified to conduct ECT through appropriate training and experience. Assisting the procedure should be an anesthesiologist or anesthetist. | In order to qualify for authorization for ECT, the provider needs to develop a treatment plan consistent with the guidance provided by Magellan’s adopted clinical practice guidelines: APA Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Second Edition APA Practice Guideline for the Treatment of Patients With Schizophrenia, Second Edition | **Criteria for Authorization:**

_The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT)._ Nothing in the criteria should suggest that electroconvulsive treatment is considered a treatment of “last resort”.

I. **Severity of Need**

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need.

A. The clinical evaluation indicates that the patient has a DSM-5 diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.

B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor. In addition to the patient’s medical status, the treatment history and the patient’s preference regarding treatment should be considered.

C. One of the following:

1) the patient has a history of inadequate response to adequate trial(s)of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); or

2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; or

3) the patient has a history of good response to ECT during an earlier episode of the illness, or

4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.

D. The patient’s status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.
E. All:
1) the patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, and
2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post-procedural care and monitoring, especially during the index ECT course, and
3) the patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.

F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service
Criteria A, B, C, D, E, F, and G must be met to satisfy the criteria for intensity and quality of service.

A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:
   1) psychiatric history, including documented past response to ECT, mental status and current functioning; and
   2) medical history and examination focusing on neurological, cardiovascular, and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT; and

B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
   1) the patient’s response to prior anesthetic inductions and any current anesthesia complications or risks, and
   2) required modifications in medications or standard anesthetic technique, if any.

C. There is documentation in the medical record specific to the patient’s psychiatric and/or medical conditions, that addresses:
   1) specific medications to be administered during ECT, and
   2) choice of electrode placement during ECT, and
   3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
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<td>D. There is continuous physiologic monitoring during ECT treatment, addressing:</td>
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<td>1) seizure duration, including missed, brief, and/or prolonged seizures, and</td>
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<td>2) duration of observed peripheral motor activity and/or electroencephalographic activity, and</td>
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<td>3) electrocardiographic activity, and</td>
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<td>4) vital signs, and</td>
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<td>5) oximetry, and</td>
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<td>6) other monitoring specific to the needs of the patient.</td>
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<td>E. There is monitoring for and management of adverse effects during the procedure, including:</td>
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<td>1) cardiovascular effects, and</td>
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<td>2) prolonged seizures, and</td>
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<td>3) respiratory effects, including prolonged apnea, and</td>
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<td>4) headache, muscle soreness, and nausea.</td>
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<td>F. There are post-ECT stabilization and recovery services, including:</td>
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<td>1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, and</td>
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<td>2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.</td>
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<td>G. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.</td>
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**Continued Stay Criteria**

Criteria A, B, and C must be met to satisfy the criteria for continued treatment.

A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:

1) the persistence of problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; or

2) the emergence of additional problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; or
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<td>3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.</td>
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<td>B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.</td>
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<td>C. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.</td>
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VII. COMMUNITY BEHAVIORAL HEALTH SERVICES

a. Psychosocial Rehabilitative Services – Adult and Child/Adolescent (H2017)

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These services encompass rehabilitation-focused, community-based psychosocial services. Community support and rehabilitative services are designed to assist recipients in strengthening or regaining interpersonal skills and in developing environmental supports necessary to function in their community.

Community support and rehabilitative services are appropriate for recipients exhibiting psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, prevocational, and educational functioning.

Psychosocial rehabilitation services are intended to restore a recipient’s skills and abilities essential for independent living. Activities include: development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services. This service combines daily medication use, independent living and social skills training, housing services, prevocational and transitional employment rehabilitation training, social support, and network enhancement to recipients and their families.

These services are designed to assist the recipient to eliminate or compensate for functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment, focusing on maximum recovery and independence. It includes work readiness assessment, job development on behalf of the recipient, job matching, on the job training, housing services, prevocational and transitional employment rehabilitation training, social support, and network enhancement to recipients and their families.

Admission Service Components – (Must provide all of the following):

1. Professional staff—Psychosocial rehabilitation services must be provided, at a minimum, by: physician, psychiatrist, PPA, psychiatric ARNP, LPHA, master’s level CAP, CAP, bachelor’s level practitioner, certified recovery peer specialist, certified psychiatric rehabilitation practitioner, certified recovery support specialist, certified behavioral health technician, or a substance abuse technician.

2. The psychiatric rehabilitation process consists of three phases – assessment, planning and implementation. Each phase involves the enrollee, the enrollee’s identified support system and the enrollee’s service provider in designing the development of wanted and needed skills and supports relevant to the enrollee’s background.

3. A functional or goal-based individualized assessment includes the completion of an evaluation of social and environmental supports and an evaluation of strengths and unmet needs in areas of psychosocial functioning as they relate to the enrollee’s goals and priorities consistent with the enrollee’s culture.

   a. Planning includes developing an enrollee –specific rehabilitation plan which establishes goals and objectives and plans for skill and support development. The plan development involves both staff and enrollee (if he/she chooses) involvement using methods appropriate to the psychiatric rehabilitation program model.

   b. In site-based programs, the implementation of services may take place individually or in groups. Group size is limited to 12 enrollees. In mobile programs, services are delivered individually (or for up to two persons, as outlined under mobile description).

The following are examples of appropriate services which should be provided as consistent with the enrollee’s services which are or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.

Or

b. There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the enrollee.

Or

c. A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.

2. The enrollee chooses to continue participation in the program.

Admission Criteria – (Must meet all of the following):

1. The presence or history of a serious mental illness, based upon medical records, which includes a DSM-5 diagnosis by a psychiatrist.

2. As a result of the mental illness, the enrollee has a moderate to severe functional impairment that interferes with or limits role 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 his/her mental illness, managing money, living more independently) relative to the enrollee’s ethnic/cultural environment; and

Continued Stay Criteria

(Must meet 1 and 2)

1. An assessment appropriate to the model of recovery indicates at least one of the following:

   a. As a result of the mental illness, there are or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.

   Or

b. There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the enrollee.

   Or

2. The enrollee chooses to continue participation in the program.
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<td>training, and job support.</td>
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<td><strong>Common Settings:</strong></td>
<td>4. <strong>Description/Characteristics of Site-Based Services:</strong></td>
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<td>Psychosocial rehabilitative services may be provided in a facility, home, or community setting.</td>
<td>a. Services combine medication use; independent living and social skills training; support to enrollees and their families; housing; pre-vocational and transitional employment rehabilitation training; social support; structured activities to diminish tendencies towards isolation and withdrawal; teaching the enrollee and family about symptom management, medication and treatment options.</td>
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<td><strong>Group size restrictions:</strong> the group size is equal to 12 or fewer.</td>
<td>b. Activities for adults and adolescents transitioning to adult services include development and maintenance of necessary daily living skills, food planning and preparation, money management, maintenance of the living environment and training in appropriate use of community services.</td>
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<td>c. Services for children and adolescents focus on helping them achieve a level of functioning that would be expected of typically developing individuals their age. Services must be individualized and directly related to goals for improving functioning.</td>
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<td>d. An initial planning process must begin upon the first day of attendance. An individualized, enrollee-specific rehabilitation assessment and plan must be developed and must be reviewed and revised every three months thereafter.</td>
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<td>e. The case record must include monthly progress notes for site-based rehabilitation.</td>
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<td><strong>Exclusion Criteria:</strong> (Any of the following)</td>
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<td>1. Enrollee’s identified problem is primarily social, financial, and/or medical (non-psychiatric) in the absence of a primary psychiatric diagnosis.</td>
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<td>2. Substance abuse is the primary source of impairment in the absence of active symptoms.</td>
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<td>3. Enrollee abandons the intent of or is incapable of moving toward independent living.</td>
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<td>4. Enrollee is a passive participant and therefore unable to participate actively in the development and execution of a rehabilitative plan.</td>
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<td><strong>Discharge Criteria</strong> (Must meet criteria 1 through 3, or 4)</td>
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<td>1. The enrollee is not expected to receive additional rehabilitative benefit from the program;</td>
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<td>2. There is a reasonable expectation that the withdrawal of services will not result in loss of rehabilitation gains or goals attained by the enrollee.</td>
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<td>3. The enrollee has successfully achieved rehabilitation goals and sustained them for a period of time as designated in the rehabilitation plan;</td>
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<td>4. The enrollee voluntarily terminates from the program.</td>
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### Service Description and Common Service Settings

**A Clubhouse** is a place where people who have a mental illness come to rebuild their lives. Clubhouse services are structured community-based group services that are provided in a group-rehabilitative setting. These services include a range of social, educational, pre-vocational, and transitional employment rehabilitation training utilizing behavioral, cognitive or supportive interventions to improve an enrollee’s potential for establishing and maintaining social relationships and obtaining occupational or educational achievements. Every opportunity provided is the result of the efforts of the enrollees and staff, who collaborate in this process.

A clubhouse group service is designed to strengthen and improve the enrollee’s interpersonal skills and to provide psychosocial therapy toward rehabilitation that emphasizes a holistic approach focusing on the enrollee’s abilities to promote recovery from his/her mental illness. This service is primarily rehabilitative in nature, using a wellness model that offers a setting to restore independent living skills. These services are designed to assist the enrollee to eliminate the functional, interpersonal and environmental barriers created by their disabilities and to restore social skills for independent living and effective life management. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment focusing on maximum recovery and independence.

#### Common Settings:
- Clubhouses shall include an individual space that allows for the

### Admission Service Components
(Must meet all of the following):

1. A Clubhouse is certified by the International Center for Clubhouse Development (ICCD); or
2. A Clubhouse is accredited by the State as an appropriate mental health provider and submits a plan for and agrees to attain ICCD certification within three years.
3. The provider must have a contract with the Department of Children and Families to specifically provide mental clubhouse services and be an enrolled Medicaid provider.
4. Clubhouse staff has 24-hour access to a State licensed independent mental health professional or a licensed psychiatrist. A Program Director shall be responsible for the delivery of daily services and be appropriately licensed by the State.
5. There is ongoing documentation of the enrollee’s activities/progress. Treatment should be enrollee-driven and goals must be documented in a treatment plan.
6. Clubhouse activity should be coordinated with all other mental health treatment providers and family enrollees.
7. An individualized crisis plan should be developed for each enrollee.

### 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 a DSM-5 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.
2. Meet requirements of particular level authorized/provided.

### 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.

### Common Settings:
- Clubhouses shall include an individual space that allows for the

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*The ICCD “Standards for Clubhouse Programs” can be viewed at [www.iccd.org](http://www.iccd.org).*
growth of its unique philosophy. This includes office/kitchen space to perform the work of the clubhouse. It can also include a thrift store to allow maximum member opportunity for work.

- Clubhouse activity extends to off-site through Transitional Employment Placements (TEP) where the enrollee can access

**Group Size restrictions**: Clubhouse services up to 12 participants per staff member.
c. Behavioral Health Day Services – Adult and Child/Adelescent (H2012)

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| **Behavioral health day services**<br>These services are designed to enable recipients to function successfully in the community in the least restrictive environment and to restore or enhance ability for personal, social, and prevocational life management services. Behavioral health day services utilize an intensive therapeutic treatment approach to stabilize the symptoms of behavioral health disorders. These services should be used to provide transitional treatment after an acute episode or to reduce or eliminate the need for more intensive levels of care. Behavioral health day services are comprised of individual, group, or family therapy services, and therapeutic care services.<br>Individual and family therapy services include the provision of insight-oriented, cognitive behavioral or supportive therapy to an individual recipient or family.<br>Individual and family therapy may involve the recipient, the recipient's family without the recipient present, or a combination of therapy with the recipient and the recipient's family. The focus or primary beneficiary of individual and family therapy services must always be the recipient.<br>Group therapy services include the provision of cognitive behavioral, supportive therapy, or counseling to individuals or families, and consultation with family or other responsible persons for sharing of clinical information. Also included is education, counseling, or advising family or other responsible persons on how to assist the recipient. Group therapy services include the provision of cognitive behavioral, supportive therapy, or counseling to recipients and their families.<br>In addition to counseling, group therapy services to recipient families and other responsible persons. | **Admission Service Components (Must meet all of the following)**<br>1. Professional staff must be:<br>   a. Either licensed or certified at the independent practice level with experience in the treatment of children and adolescents; or<br>   b. Unlicensed and supervised at least weekly by an appropriately licensed professional, and<br>   c. Services provided must be within the therapist's scope of training.<br>2. Complete biopsychosocial assessment including, but not limited to the enrollee's relevant history, previous treatment, current medical conditions (including medications), substance abuse history, personal strengths, lethality assessment and mental status.<br>3. Development of an individualized, strengths-based, targeted, focused treatment plan directed toward the reduction or alleviation of the impairment that resulted in the enrollee seeking treatment. The plan must reflect the least restrictive, most efficacious treatment available.<br>4. Development of specific, achievable, behaviorally based and objective treatment goals which directly address the problems that resulted in the enrollee seeking treatment. | **Admission Criteria (Must meet all of the following):**<br>1. Be age 2 years or older, and<br>2. Score in at least the moderate impairment range on a behavior and functional rating scale developed for this age group demonstrating impairments as described below:<br>   a. Level of Stability<br>      i. Risk to self, others or property is not imminent (although without treatment the enrollee's potential risk in these areas may be increased).<br>      ii. The enrollee is medically stable and does not require a level of care that includes more intensive medical monitoring.<br>      iii. Treatment is directed to the acute symptoms which place enrollee at risk and/or impair functioning.<br>   b. Degree of Impairment:<br>      i. Enrollee exhibits impairments in cognitive, affective, or behavioral abilities.<br>      ii. Social/Interpersonal/Familial– Enrollee exhibits impairment in social, interpersonal or familial functioning arising from a psychiatric disorder or a serious emotional disturbance which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.<br>      iii. Vocational/Educational– Enrollee exhibits impairment in occupation or educational functioning arising from a psychiatric disorder or a serious emotional disturbance which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition. | **Continued Stay Criteria (Must meet 1 and 2)**<br>1. Be at least 2 years old, and<br>2. Score in at least the moderate impairment range on a behavior and functional rating scale developed for this age group<br>**Exclusion Criteria (Any one of the following):**<br>1. Enrollee scores in the low impairment range on a behavior and functional rating scale.
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<td>include education, the sharing of clinical information, and guidance on how to assist recipients. Therapeutic care services assist the recipient in the development of the skills necessary for independent living and for symptom management. Progress toward treatment goals related to therapeutic care services should be assessed through observation. For enrollees ages 2-5 years, services are designed to strengthen individual and family functioning, prevent more restrictive placement of enrollees, and provide an integrated set of interventions to promote behavioral and emotional adjustments. Services must be provided in a milieu and be delivered in a coordinated manner and be age appropriate to the enrollee. Medicaid will not reimburse for behavioral health day services where total group size for group therapy exceeds 15 participants who are receiving treatment for a mental health disorder. For group therapy where enrollees are 2 years to 5 years, the total group membership may not exceed 10 participants. For reimbursement, the service must be provided for a minimum of two hours per day, per enrollee. At least one hour per day must consist of individual, group therapy, or family services (may be a combination of these services). Medicaid will not reimburse for behavioral health day services the same day as psychosocial rehabilitation services.</td>
<td>3. Treatment plan has been modified to reflect enrollee’s progress and/or new information has become available during the outpatient treatment. 4. Routine assessments and treatment progress updates are completed. 5. Enrollee and family, to the extent possible, are involved in treatment and discharge planning. 6. Natural community supports are identified. Program Requirements for Enrollees Ages 2 years through 5 years (must meet all of the following requirements: 1) Services must be provided for a minimum of two to a maximum of four hours within the day. This need not be a continuous time period, but must be provided in one day. Therapeutic activities, as listed in the enrollee’s treatment plan, must be interwoven throughout the enrollee’s scheduled activities. 2) The day treatment program must have a parent or caregiver component. At a minimum, there should be a monthly face-to-face contact with the parent or caregiver at the day treatment center or at the enrollee’s home. 3) If the provider is unable to involve the parent or caregiver or meet the requirement for the face-to-face contact, a telephone contact is allowable, but is not reimbursable as part of day treatment. Written justification of why the face-to-face intervention could not occur must be provided in the enrollee’s clinical record. 4) The group size during therapeutic activities must not exceed 10 enrollees. 5) The behavioral health day services staff-to-enrollee ratio during therapeutic rating scale. 2. Enrollee’s condition has active components of significant risk to self or others or property such that a higher level of care is medically necessary.</td>
<td>Discharge Criteria (Any one of the following): 1. Enrollee no longer meets continued stay medical necessity criteria. 2. Enrollee withdraws from treatment against medical advice.</td>
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<td>activities cannot exceed 1:5. Infant mental health aides may be used to meet these staffing requirements. 6) Prior to a enrollee receiving behavioral health day services, a physician or a LPHA experienced in the diagnosis of mental disorders in young children must provide written certification that: • Enrollee meets the service eligibility criteria. • Services can be expected to slow deterioration, or maintain or improve the enrollee’s condition and functional level. • Enrollee’s condition or functional level cannot be improved in a less restrictive level of care.</td>
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<td>Therapeutic behavioral on-site services are intended to prevent recipients who have complex needs from requiring placement in a more intensive, restrictive behavioral health setting. These services are coordinated through individualized treatment teams and are designed to assist recipients and their families. Therapeutic behavioral on-site services are intended to maintain the recipient in the home (permanent or foster). Services are limited to recipients under the age of 21 years meeting specific eligibility criteria. A thorough assessment must be completed. If the assessment indicates a need for intensive, clinical therapeutic behavioral on-site services, and the family agrees to these services, the following services are reimbursable under Medicaid: • Therapeutic behavioral on-site—therapy services • Therapeutic behavioral on-site—behavior management services • Therapeutic behavioral on-site—therapeutic support services</td>
<td>Admission Service Components (Must meet all of the following) 1. Complete biopsychosocial strengths-based assessment following Best Practice Guidelines either included in or accompanying a psychological or psychiatric evaluation. 2. Development of an individualized, strengths-based treatment plan which includes specific achievable, behaviorally based and objective treatment goals. Goals directly address the problems that resulted in the need for treatment and build on the enrollee’s and his/her family’s strengths. Treatment goals describe the roles that will be taken by all relevant participants in addition to the enrollee (e.g., family enrollees, school staff, if relevant, etc). 3. Services are supervised by a qualified health professional. a. Therapy services must be provided by a physician, psychiatrist, LPHA, master’s level CAP, master’s level practitioner. b. Management services must be provided by a certified behavior analyst or certified associate behavioral analyst, working as a member of the enrollee’s treatment team and by one of the following with 3 years of behavioral analysis experience and 10 hours of behavioral analysis training every year: clinical social worker, mental health counselor, marriage and family therapist, or psychologist. c. On-site therapeutic support services must be provided, at a minimum, by a physician, psychiatrist, PPA, psychiatric ARNP, LPHA, master’s level CAP, master’s level practitioner, certified behavior analyst,</td>
<td>Admission Criteria (Must meet one of the following) 1. Under the age of 2 years and meets one of the following criteria: a. Exhibiting symptoms of an emotional or behavioral nature that are atypical for the enrollee’s age and development that interferes with social interaction and relationship development. b. Failure to thrive (due to emotional or psychosocial causes, not solely medical issues). 2. Ages 2 years through 5 years and meets both of the following criteria: a. Exhibiting symptoms of an emotional or behavioral nature that are atypical for the enrollee’s age and development. b. Score in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group. 3. Ages 6 years through 17 years and meets one of the following criteria: a. Have an emotional disturbance. b. Have a serious emotional disturbance. c. Have a substance use disorder. 4. Ages 18 years through 20 years, but otherwise meets the criteria for an emotional disturbance or a serious emotional. 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. There is a reasonable expectation that the enrollee will benefit from the continuation of Home/Community Services. 3. Treatment promotes developmentally appropriate behavior, activities, skills and social skills for the enrollee in his/her</td>
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| and the skill deficits and assets of the recipient and recipient’s family, caregivers, and other involved persons  
  • Development of an individual behavior plan, with measurable goals and objectives that must be integrated into the recipient’s treatment plan  
  • Training the recipient’s family, caregivers, and other involved persons in the implementation of the behavior plan  
  • Monitoring interactions between the recipient and the recipient’s family, caregivers, and other involved persons to measure progress  
  • Coordinating treatment plan services | certified assistant behavior analyst, certified recovery peer specialist, certified psychiatric rehabilitation practitioner, certified behavioral health technician. | natural context through focusing on his/her individual strengths and needs. |
| Therapeutic Support Services | 4. There is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan. | 4. Techniques are employed in treatment that are time limited in nature and subordinate to a goal of enhanced autonomy. |
| Therapeutic behavioral on-site therapeutic support services include the following:  
  • One-to-one supervision and intervention with the recipient during therapeutic activities  
  • Providing skills training in accordance with the recipient’s treatment plan to the recipient for restoration of basic living and social skills  
  • Assistance to the recipient and the recipient’s family, caregivers, and other involved persons in implementing the recipient’s behavior plan | 5. The treatment team must include the enrollee and family, other persons who provide natural, informal support to the family system and the professionals involved in providing services. The child-specific plan for therapeutic behavioral on-site services must be based on a thorough assessment, with information from the enrollee and family, regarding needs, strengths and desired outcomes of services. When indicated by the assessment, and agreed to by the family, the plan must reflect referral to, and coordination with, other agencies and resources. It is recognized that involvement of the family in the treatment of the enrollee is necessary and appropriate. Provision of therapeutic behavioral on-site services with the family must clearly be directed toward meeting the identified treatment needs of the enrollee. | 5. Appearance of new problems or symptoms which meet admission guidelines. |
| 6. The enrollee and the enrollee’s family should collaborate with the treating staff to develop the enrollee’s individualized formal aftercare plan within 45 days of admission to therapeutic behavioral on-site services. A formal aftercare plan should include community resources, activities, services, and supports that will be utilized to help the enrollee sustain gains achieved during treatment. | 6. Enrollee requires the continuation of a treatment support system while in the community until an effective family and community support network can be activated. | |
| Continued Stay Service Components | | Exclusion Criteria  
(Any one of the following): |
| 1. Treatment is in process of implementation | | 1. Site of service is not where the primary problems or behaviors of the psychiatric diagnosis are manifested. |
| 2. Active and timely treatment is focused upon stabilizing or reversing symptoms for which treatment was initiated (or prescribed). | | 2. Enrollee is simultaneously receiving similar therapeutic services of equal or greater intensity via another resource, |
| | | Discharge Criteria  
(Must meet all of the following): |
<p>| | | 1. Enrollee no longer meets Continued Stay Criteria. |
| | | 2. Enrollee meets the individualized discharge criteria. Within 45 days of admission to therapeutic behavioral on-site services, a plan must be developed with each enrollee and family, which contains specific discharge criteria. The discharge plan must be placed in the enrollee’s clinical record. |</p>
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<td>3. Interventions are consistent with the enrollee’s risk factors and assessment.</td>
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<td>4. Treatment plan and service hours have been adjusted to reflect the enrollee/family’s progress.</td>
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<td>5. Routine assessments and treatment progress updates are completed.</td>
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<td>6. Enrollee and family, to the extent possible, are involved in treatment and discharge planning.</td>
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<td><strong>Continued Stay Documentation Requirement</strong></td>
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<td>Continued Stay Documentation Requirement</td>
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<td>Within six months of the original determination of eligibility for services and every six months thereafter, the members of the enrollee’s treatment team must document that the enrollee continues to meet the eligibility criteria stated above. Services may be authorized for less than six months</td>
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**Behavioral Health Overlay Services**

Behavioral Health Overlay Services include mental health, substance abuse, and supportive services designed to meet the behavioral health treatment needs of enrollees 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 enrollee'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** – includes insight-oriented, cognitive-behavioral, or supportive therapy to the enrollee or family.
- **Group Therapy** – includes provision of cognitive-behavioral or supportive therapy to enrollees and families and consultation with family or other responsible persons for sharing of clinical information. Group size should not exceed 15 participants.
- **Behavior management** – includes assessing behavioral problems, and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the enrollee’s behaviors and the interactions that motivate, maintain, or improve behavior, developing an individual behavior plan with measurable goals and objectives, training caregivers and other involved person in the implementation of the behavior plan, monitoring the implementation of the behavior plan, monitoring the behavior plan, monitoring the behavior plan, monitoring the behavior plan, monitoring the behavior plan, monitoring the behavior plan, monitoring the behavior plan, monitoring the behavior plan.

**Covered for enrollees under the age of 21 in child welfare settings ONLY.**

**Service Components (Must meet all of the following)**

1. Assessment must be completed prior to the development of the treatment plan and address mental health status, substance abuse concerns, functional capacity, strengths, and service needs or had an assessment on file within the past 6 months.
2. Enrollee must have a treatment plan developed in compliance with the Community Behavioral Health Services Coverage and Limitation Handbook. If the treatment plan has a behavioral management component, a behavioral analyst must review and sign.
3. The enrollee and treating staff should collaborate and develop a formal aftercare plan.

**Therapy**

Must be provided by a physician, psychiatrist, PPA, ARNP, LPHA, master’s level CAP, or a master’s level practitioner.

**Group Therapy**

Must be provided by a physician, psychiatrist, PPA, Psychiatric ARNP, LPHA, master’s level CAP, master’s level practitioner, or a bachelor’s level practitioner. Group size must not exceed 15 participants.

**Behavior Management**

Must be provided by a certified behavior analyst or certified assistant behavior analyst, or by one of the following licensed practitioners who has three years of behavior analysis experience and 10 hours of documented training every year in behavior analysis: clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

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**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 (DSM 5 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:
- 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.
- Has exhibited physical aggression or violent behavior toward people, animals, or property; this risk may also be evidenced by current threats of such aggression.
- Has run away from home or placements or threatened to run away on one or more occasions.
- Has had an occurrence of sexual aggression.
- 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:**

Enrollee must continue to meet the admission criteria.

**Exclusion Criteria**

Enrollee has a cognitive deficit severe enough to prohibit the service from being a benefit to the enrollee.

**Discharge Criteria**

(Must meet all of the following):

1. Enrollee no longer meets Continued Stay Criteria.
2. Enrollee meets the individualized discharge criteria.
### Service Description and Common Service Settings

The enrollee and caregiver progress and revising the plan as needed, and coordinating services on the treatment plan with the treatment.

- Therapeutic support services are direct care contacts that must be related to the recipient’s treatment plan goals and objectives and must include one or more of the following services, as medically necessary:
  - One-to-one supervision and intervention with the recipient during therapeutic activities in accordance with the recipient’s treatment plan.
  - Skill training of the recipient for restoration of those basic living and social skills necessary to function in the recipient’s own environment.
  - Assistance to the recipient in implementing the behavioral goals identified through assessments, therapy, and development of the treatment plan.

- 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 in 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 ongoing communication with the recipient during therapeutic home assignments.

### Magellan Specifications

**Therapeutic Support**

Must be provided by a physician, psychiatrist, PPA, Psychiatric ARNP, LPHA, master’s level CAP, master’s level practitioner, bachelor’s level practitioner, certified behavior analyst, certified

**Behavioral Health Overlay Services Exclusions**

Case management 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.

**Therapeutic Home 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.

### Magellan Utilization Management Guidelines
## IX. SPECIALIZED THERAPEUTIC GROUP CARE SERVICES (H0019)

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<td>Therapeutic group care services or Specialized Therapeutic Group Care are community-based, psychiatric residential treatment services 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. Therapeutic group care services are intended to support, promote, and enhance competency and participation in normal age-appropriate activities of recipients who present moderate to severe psychiatric, emotional, or behavior management problems related to a psychiatric diagnosis. Programming and interventions are highly individualized and tailored to the age and diagnosis of the recipient. Therapeutic group care is intended to provide a high degree of structure, support, supervision, and clinical intervention in a home-like setting. Therapeutic group care services are a component within Florida Medicaid’s behavioral health system of care for recipients under the age of 21 years. They are appropriate for recipients under the age of 21 years who are ready to transition from a more restrictive residential treatment program or for those who require more intensive care.</td>
<td>Admission Service Components (Must meet all of the following): 1. A provider of TGCS must be: a. Be enrolled as a community behavioral health services group provider (provider type 05). b. Be properly licensed in accordance with Chapter 394, F.S., and Chapter 65E-9, F.A.C., by the Agency for Health Care Administration (AHCA). c. Achieve compliance on the Community Behavioral Health Services Provider Pre-Enrollment Certification Review. 2. Services are intended to support, promote and enhance competency and participation in normal age-appropriate activities of enrollees who present moderate to severe psychiatric, emotional or behavioral management problems related to a psychiatric diagnosis. 3. Programming and interventions are highly individualized and tailored to the age and diagnosis of the child. 4. The provider of TGCS must be able to provide: a. A home-like, therapeutic group care setting serving no more than 12 recipients. b. A therapeutic environment with an identified treatment orientation described and supported in the literature and that is understood by all staff and by the recipients. c. Psychiatric services and clinical assessment, treatment planning, and therapy services by qualified staff, per the requirements in this handbook. d. Consistent implementation of programmatic policy by administrative, clinical, and direct care staff within the therapeutic group care program. e. A range of age-appropriate indoor and outdoor recreational and leisure activities, including activities for nights and weekends, based on group and individual interests and developmental needs. f. Access to, and coordination with, an accredited educational program for each recipient that complies with the State Board of Education, Rule 6A-6.0361, F.A.C. g. Access to and coordination with primary care providers. h. Behavioral programming that is individually designed and implemented and includes structured interventions and contingencies to support the development of adaptive, prosocial, interpersonal behavior.</td>
<td>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, and that the member is ready to transition to a less restrictive level of care. 2. Which provides a rationale why the individualized programming and interventions for each member cannot be safely and/or effectively furnished at a non-residential level of care. 3. Has a serious emotional disturbance. Continued Stay Criteria (Must meet 1 through 3) 1. The multidisciplinary team must recommend TGCS no less often than every six months—which continues to address admission criteria #2 2. The focus of services must be directly related to the member’s mental health or substance abuse 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. Member has medical issues that prevent utilization of therapeutic group care services. 3. Member is not likely to benefit from treatment in this LOC (e.g. member has an IQ &lt; 70). 4. 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 the member will not be compromised with treatment being given at a less restrictive level of care.</td>
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| community-based treatment to avoid placement in a more restrictive residential treatment setting. The recipient’s primary diagnosis and level of functioning are the reasons for treatment and the focus of the interventions and services provided. Generally, these services include psychiatric and therapy services, therapeutic supervision, and the teaching of problem solving skills, behavior strategies, normalization activities, and other treatment modalities, as authorized in the treatment plan. Providers must comply with the regulations listed in the Specialized Therapeutic Services Coverage and Limitations Handbook. | i. Psychiatric crisis management with demonstrated 24-hour response capability and access to acute care setting and behavioral health emergency management services. j. The provider must meet the staffing requirements specified in Rule 65E-9.006, F.A.C. 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. | intensive level of care. 2. A comprehensive discharge plan has been developed in consideration of the member’s; a. Strengths b. Compliance with past treatment c. Social and/or familial support system d. Resources and skills e. Identification of triggers for relapse, and other factors/obstacles to improvement, and f. Living arrangements 3. Discharge is not likely to interfere with gains achieved while in therapeutic group care services. The plan reimburses services that are determined medically necessary and not duplicative. Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines “medically necessary” or “medical necessity” as follows: "[T]he medical or allied care, goods, or services furnished or ordered must: (a) Meet the following conditions: 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs. 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. 4. 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. 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." “(c) 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 covered service."
### X. SPECIALIZED THERAPEUTIC FOSTER CARE SERVICES (S5145, S5145 HE, S5145 HK)

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| 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 and short-term treatment and crisis intervention. Specialized therapeutic foster care services and crisis intervention are available at either Level I or Level II intensity depending upon the needs to the enrollee. The three specialized therapeutic foster care services are: | Specialized therapeutic foster care services are intensive treatment services provided to enrollees with emotional disturbances that reside in a state licensed foster home. Specialized therapeutic foster care services are appropriate for long-term and short-term treatment and crisis intervention. Specialized therapeutic foster care services and crisis intervention are available at either Level I or Level II intensity depending upon the needs to the enrollee. The three specialized therapeutic foster care services are: | **Admission Criteria – Level I (Must meet 1-3)**

Level I is for an enrollee who has:

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

Provider Requirements

Providers must be linked to a treating psychiatrist (provider type 25 or 26). Specialized therapeutic foster care providers must complete the Specialized Therapeutic Foster Care Provider Agency Self-Certification, found in the appendices. This self-certification also requires the signature of DCF or its designee. Providers must submit the completed self-certification to the Medicaid fiscal agent with their enrollment application.

The following conditions must be met before the provider can enroll in Medicaid as a specialized therapeutic foster care provider:

- The provider’s primary clinicians, psychologists, psychiatrists, and foster parents delivering specialized therapeutic foster care services must meet the specific education and training requirements.
- The provider employs or contracts with primary clinicians and foster care parents who provide the services. (The primary clinicians and foster care parents are not individually enrolled in Medicaid.)
- The provider has an approved pre-service and in-service training plan for staff providing specialized therapeutic foster care services.
- The foster home is properly licensed in accordance with Chapter 409.175, F.S. and Chapter 65C-13 or 65C-14, F.A.C., by the circuit Child Welfare and Community-Based Care program office.
- The foster parents have received basic training required of all licensed foster parents and meet all other licensing requirements.
- The provider has a financial agreement with the foster parents that reimburses the foster parents for their therapeutic intervention services.
- The provider has policies and procedures that promote good therapeutic practice, ensure that therapeutic foster parents are the primary therapeutic agent, provide for appropriate treatment plans and documentation, and protect the rights of recipients and their families.
- The provider has a program evaluation system to review the process and

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
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| 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 | outcomes on at least an annual basis. • The provider has policies and procedures that are consistent with section 1003.57(3)(b), F.S. to address the school notification requirements. **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 • Level of care recommendation from the MDT. Other specifications: • A treatment plan must be developed by the primary clinician within the following number of days of admission: • Level I—30 days • Level II—14 days • Crisis intervention—14 days • A psychiatrist must interview the enrollee to assess progress toward meeting treatment goals. A psychiatrist must update the treatment plan on an as needed basis, but at least: • Level I – on a quarterly basis; or • Level II and Crisis Intervention – on a monthly basis. • The treatment needs of the enrollee require that a specialized therapeutic foster care provider be available 24 hours per day to respond to crises or to the need for special therapeutic interventions. This may require that one of the foster parents not work outside the home • For crisis intervention services, a comprehensive behavioral health assessment must be initiated (through referral), by the vendor, within 10 working days of crisis intervention placement for any enrollee who has not been previously authorized for specialized therapeutic foster care and has not had a comprehensive behavioral health assessment within the past year. | 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: a. Enrollee’s strengths, social and/or familial support system, resources and skills, identification of triggers for relapse; and other factors/obstacles to improvement, and The plan reimburses services that are determined medically necessary and not duplicative. Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines “medically necessary” or “medical necessity” as follows: “[T]he medical or allied care, goods, or services furnished or ordered must: (a) Meet the following conditions:
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<tr>
<td><strong>Level II specialized therapeutic foster care</strong> is intended to provide a high degree of structure, support, supervision, and clinical intervention. <strong>Crisis Intervention Services</strong> 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.</td>
<td>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. <strong>Serious Emotional Disturbance</strong> 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.</td>
<td>1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs. 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational. 4. 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. 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.” “(c) 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 covered service.”</td>
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### XI. MENTAL HEALTH TARGETED CASE MANAGEMENT
**a. Adult (T1017)**

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<tr>
<td>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.</td>
<td>Admission Service Components (Must meet all of the following)</td>
<td>Admission Criteria (Must meet 1 through 8; or 9)</td>
</tr>
</tbody>
</table>
| | 1. Services are organized as a separate service, meet the Mental Health Targeted Case Management Coverage and Limitations Handbook requirements and are supervised by a qualified mental health professional.  
   a. The supervisor (if certified on or after July 1, 1999) either has a master’s degree or a bachelor’s degree with five years of case management experience and case management training required by the Department of Children and Families.  
   b. Case Management program workers are supervised closely and services provided are within the workers scope of training and experience.  
   c. Services are coordinated with the enrollee’s mental health therapist or psychiatrist (when enrollee is receiving such services), and involved others.  
   d. Formal and informal linkages with other services providers are established to carry out Case Management functions.  
   2. Complete biopsychosocial assessment including, but not limited to relevant history, education or employment, social skills, independent living skills, previous treatment, current medical conditions (including medications), substance abuse history, lethality assessment and a complete Mental Status Exam.  
   3. Development of an individualized strengths-based, targeted, focused treatment plan directed toward the reduction or alleviation of the impairment that resulted in the enrollee seeking | 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. |
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<tr>
<td>Services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each recipient and must not simply reflect the Medicaid maximum allowable for the service.</td>
<td>Services. The plan must reflect the least restrictive, most efficacious services available.</td>
<td>This is observable as a positive or beneficial response to services which may include, but are not limited to:</td>
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<tr>
<td>Adult mental health targeted case management for recipients age 18 years and older.</td>
<td>4. Development of specific, achievable, behavioral-based and objective goals which directly address the programs that resulted in the enrollee seeking services.</td>
<td>a. Consistently attending scheduled therapy sessions/Case Management meetings,</td>
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<td></td>
<td>5. Service plan developed by the resource coordinator with the enrollee, and family which includes:</td>
<td>b. Independent living and community integration,</td>
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<td></td>
<td>a. Documented assessment of the enrollee’s strengths and needs.</td>
<td>c. Vocational/educational participation,</td>
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<td></td>
<td>b. Specific goals, objectives, responsible persons, time frames for completion and the case manager’s role in relating to the enrollee and involved others.</td>
<td>d. Reduced hospital lengths of stay,</td>
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<td></td>
<td>c. Signatures of the enrollee, the case manager and the case manager’s supervisor.</td>
<td>a. Reduced use of crisis-only services.</td>
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<td></td>
<td>6. Assistance provided in linking with services, gaining access to services, monitoring the delivery of services, problem resolution, use of community resources, and network building.</td>
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<tr>
<td>Continued Stay Criteria (Must meet all of the following)</td>
<td>This is observable as a positive or beneficial response to services which may include, but are not limited to:</td>
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</tr>
<tr>
<td>1. Written Case Management plan has been implemented, and modified to reflect enrollee’s progress and/or new information.</td>
<td>a. Consistently attending scheduled therapy sessions/Case Management meetings,</td>
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<tr>
<td>2. Active and timely services are being provided where the enrollee resides or needs service.</td>
<td>b. Independent living and community integration,</td>
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<td>3. Face-to-face contact is made at least every month for an adult enrollee.</td>
<td>c. Vocational/educational participation,</td>
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<td>4. Interventions are consistent with the enrollee’s service plan and demonstrate enrollee is accessing services and needed resources or is exhibiting improved functioning with Case Management Services.</td>
<td>d. Reduced hospital lengths of stay,</td>
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<td></td>
<td>a.</td>
<td>a. Reduced use of crisis-only services.</td>
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<td>b.</td>
<td>This is observable as a positive or beneficial response to services which may include, but are not limited to:</td>
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<td></td>
<td>c.</td>
<td>a. Consistently attending scheduled therapy sessions/Case Management meetings,</td>
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<td></td>
<td>d.</td>
<td>b. Independent living and community integration,</td>
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<td>e.</td>
<td>c. Vocational/educational participation,</td>
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<td></td>
<td>f.</td>
<td>d. Reduced hospital lengths of stay,</td>
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<td></td>
<td>g.</td>
<td>a. Reduced use of crisis-only services.</td>
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<td>Exclusion Criteria (Any one of the following):</td>
<td>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.</td>
<td></td>
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<tr>
<td>1. Enrollee or enrollee’s representative does not accept Mental Health Targeted Case Management (MHTCM).</td>
<td>4. Techniques employed in Case Management are time limited in nature and subordinate to a goal of enhanced enrollee autonomy.</td>
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<tr>
<td>2. MHTCM is not endorsed by the enrollee’s primary mental health providers.</td>
<td>Discharge Criteria (Must meet 1 and 2)</td>
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<td>3. Enrollee does not meet the Admission guidelines for MHTCM.</td>
<td>1. Enrollee no longer meets continued stay criteria.</td>
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<td>4. Enrollee requires services of a higher intensity (e.g., residential treatment).</td>
<td>2. A discharge plan had been developed including:</td>
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<tr>
<td>5. Enrollee is residing in a nursing facility, state psychiatric hospital, or intermediate care facility for the developmentally disabled.</td>
<td></td>
<td>a. A recommended aftercare plan which contains the signature of the enrollee, involved others, and</td>
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<tr>
<td>6. Enrollee is enrolled in FACT.</td>
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<td>b. A transition session is scheduled with the aftercare interagency team.</td>
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<tr>
<td>7. Diagnosis of primary substance disorder or developmental disability disorder.</td>
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b. Child and Adolescent (T1017 HA)

<table>
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<tr>
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<tbody>
<tr>
<td>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. The purpose of mental health targeted case management services is to assist individuals (recipients) in gaining access to needed medical, social, educational, and other services. The primary goal of mental health targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each recipient and must not simply reflect the Medicaid maximum allowable for the service. Children mental health targeted case management for recipients age birth through 17 years old.</td>
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**Admission Service Components (Must meet all of the following)**

1. Services are organized as a separate service, meet the Mental Health Targeted Case Management Coverage and Limitations Handbook requirements and are supervised by a qualified mental health professional.
   a. The supervisor (if certified on or after July 1, 1999) either has a master’s degree or a bachelor’s degree with five years of case management experience and case management training required by the Department of Children and Families.
   b. Case Management program workers are supervised closely and services provided are within the workers scope of training and experience.
   c. Services are coordinated with the enrollee’s mental health therapist or psychiatrist (when enrollee is receiving such services), and involved others.
   d. Formal and informal linkages with other services providers are established to carry out Case Management functions.
2. Complete biopsychosocial assessment including, but not limited to relevant history, education or employment, social skills, independent living skills, previous treatment, current medical conditions (including medications), substance abuse history, lethality assessment and complete Mental Status Exam.
3. Development of an individualized strengths-based, targeted, focused plan directed toward the reduction or alleviation of the impairment that resulted in the enrollee seeking services. The plan must reflect the least restrictive, most efficacious services available.

**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.
### Service Description and Common Service Settings

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<tr>
<td>4. Development of specific, achievable, behavioral-based and objective goals which directly address the programs that resulted in the enrollee seeking services.</td>
<td>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:</td>
</tr>
<tr>
<td>5. Service plan developed by the resource coordinator with the enrollee, and family, which includes:</td>
<td>a. Consistently attending scheduled therapy sessions/Case Management meetings,</td>
</tr>
<tr>
<td>a. Documented assessment of the enrollee’s strengths and needs.</td>
<td>b. Family and community integration,</td>
</tr>
<tr>
<td>b. Specific goals, objectives, responsible persons, time frames for completion and the case manager’s role in relating to the enrollee and involved others.</td>
<td>c. Vocational/educational participation,</td>
</tr>
<tr>
<td>c. Signatures of the enrollee, the family, the case manager and the case manager’s supervisor.</td>
<td>d. Reduced hospital lengths of stay or child out-of-home placement,</td>
</tr>
<tr>
<td>6. Assistance provided in linking with services, gaining access to services, monitoring the delivery of services, problem resolution, use of community resources, and network building.</td>
<td>e. Reduced use of crisis-only services.</td>
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#### Continued Stay Criteria

*Must meet all of the following*

1. Written Case Management plan has been implemented, and modified to reflect enrollee’s progress and/or new information.
2. Active and timely services are being provided where the enrollee resides or needs service.
3. Face-to-face contact is made at least twice per month for a child enrollee or the family.
4. Interventions are consistent with the enrollee’s service plan and demonstrate enrollee is accessing services and needed resources or is exhibiting improved functioning with Case Management Services.

#### 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 requires services of a higher intensity (e.g., residential treatment).
5. Diagnosis of primary substance disorder or developmental disability disorder.

#### Discharge Criteria

*Must meet 1 and 2*

1. Enrollee no longer meets continued stay criteria.
2. A discharge plan had been developed including:
   a. A recommended aftercare plan which contains the signature of the enrollee, the family, involved others, and
   b. A transition session is scheduled with the aftercare interagency team.
## c. Intensive case management (T1017 HK)

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</table>
| **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. The primary goal of mental health targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each recipient and must not simply reflect the Medicaid maximum allowable for the service. Intensive case management team services provide team case management to adults with serious and persistent functional impairments. | **Admission Service Components**
(Must meet all of the following)
1. Services are organized as a separate service, meet the Mental Health Targeted Case Management Coverage and Limitations Handbook requirements and are supervised by a qualified mental health professional as follows:
   a. The supervisor (if certified on or after July 1, 1999) either has a master’s degree or a bachelor’s degree with five years of case management experience and case management training required by the Department of Children and Families.
   b. Unlicensed program workers are supervised closely and services provided are within the workers scope of training and experience.
   c. Services are coordinated with the enrollee’s mental health therapist or psychiatrist (when enrollee is receiving such services) and consultation is provided in crisis situations, overall treatment and care management, and in discharge planning.
   d. Services are provided when an enrollee is being considered for involuntary commitment.
   e. Formal and informal linkages with other services providers are established to carry out ICM activities.
   f. Services are available on a 24 hours, 7-day per week basis.
2. Complete biopsychosocial assessment including, but not limited to relevant history, education or employment, social skills, independent living skills, previous treatment, current medical conditions (including medications), substance abuse history, lethality assessment and a complete Mental Status Exam.
3. Development of an individualized strengths-based, targeted, focused plan directed toward the reduction or alleviation of the impairment that resulted in the enrollee seeking services. The plan must reflect the least restrictive, most efficacious services available.
4. Development of specific, achievable, behavioral-based and objective goals which directly address the programs that resulted in the enrollee seeking services. |
| **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

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| **intensive illness to assist the recipient to remain in the community and avoid institutional care.** | **5. Service plan developed by the case manager with the enrollee, which includes:**  
  a. Documented assessment of the enrollee’s strengths and needs.  
  b. Specific goals, objectives, responsible persons, time frames for completion, and the intensive case manager’s role in relating to the enrollee and involved others.  
  c. Signatures of the enrollee, the intensive care manager, and the intensive case manager supervisor. | 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. |
| **Intensive team case managers coordinate needs assessment, services planning, and provide service oversight.** | **6. Assistance provided in linking with services, gaining access to services, monitoring the delivery of services, problem resolution, use of community resources, and network building.** |  
  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. |
| **Intensive case management team services is for recipients age 18 years and older.** | **Continued Stay Components (Must meet all of the following)**  
  1. Written Case Management plan has been implemented, and modified to reflect enrollee’s progress and/or new information.  
  2. Active and timely services are being provided where the enrollee resides or needs service.  
  3. Contact is made with the enrollee or the family at least once every two weeks.  
  4. Interventions are consistent with the enrollee’s service plan. |  
  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. |
| **Continued Stay Components (Must meet all of the following)** | **Discharge Criteria (Must meet 1 and 2)**  
  1. Enrollee no longer meets continued stay criteria.  
  2. A discharge plan had been developed including:  
  a. A recommended aftercare plan which contains the signature of the enrollee, involved others, and the signature of the county administrator if the child/family does not consent to termination,  
  b. A transition session is scheduled with the aftercare interagency team. |  
  1. Enrollee no longer meets continued stay criteria.  
  2. A discharge plan had been developed including:  
  a. A recommended aftercare plan which contains the signature of the enrollee, involved others, and the signature of the county administrator if the child/family does not consent to termination,  
  b. A transition session is scheduled with the aftercare interagency team. |
## XII. TARGETED CASE MANAGEMENT FOR CHILDREN AT RISK OF ABUSE AND NEGLECT (T2023 HA)

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<td><strong>Targeted Case Management:</strong> A set of interrelated activities under which a specific person (case manager) locates, coordinates, and monitors appropriate services for a recipient. The purpose of case management is to assist recipients in the target group to gain access to medical, social, educational, and other services.</td>
<td><strong>Covered Services</strong>&lt;br&gt;Targeted case management (TCM) services for children at risk of abuse and neglect include:&lt;br&gt;• Collecting all assessment data.&lt;br&gt;• Developing an individualized plan of care.&lt;br&gt;• Coordinating needed services and providers.&lt;br&gt;• Making home visits and collateral contacts as needed.&lt;br&gt;• Maintaining client case records.&lt;br&gt;• Monitoring and evaluating client progress and service effectiveness.</td>
<td><strong>Admission Criteria</strong>&lt;br&gt;Must meet one of the following targeted case management services for children at risk of abuse and neglect criteria:&lt;br&gt;(1) Is or has been determined to present at least two of the following seven risk factors in the last 12 months:&lt;br&gt;(a) Child of a parent who is unable to meet the child’s basic needs (access to food, clothing, transportation).&lt;br&gt;(b) Child of a parent who has inadequate income or housing.&lt;br&gt;(c) Child of a parent who is socially isolated or has limited natural supports.&lt;br&gt;(d) Child who is a witness to domestic violence.&lt;br&gt;(e) Child of a parent with a history of mental illness requiring treatment or hospitalization.&lt;br&gt;(f) Child of a mother who, upon knowledge of pregnancy, used tobacco, alcohol, or drugs.&lt;br&gt;(g) Child of a mother who received little to no prenatal care (less than five visits).&lt;br&gt;(2) Is the child of a parent who is or has been a victim of domestic violence.&lt;br&gt;(3) Is the child of a parent suffering from mental health concerns, post-partum depression, or substance abuse problems.&lt;br&gt;(4) Is the subject of a report of abuse and neglect made to the Department of Children and Families that did not result in a court order into foster care, shelter care, or protective supervision.</td>
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<td><strong>Target Group:</strong>&lt;br&gt;Recipients under the age of 18 years who:&lt;br&gt;• Are Medicaid eligible&lt;br&gt;• Have a parent request services&lt;br&gt;• Are not receiving targeted case management under another program&lt;br&gt;• Meet the certification criteria</td>
<td><strong>Case Load Ratio</strong>&lt;br&gt;The maximum average case load ratio for services is 25 recipients per one targeted case manager.</td>
<td><strong>Continued Stay Criteria</strong>&lt;br&gt;(Must meet 1 through 4)&lt;br&gt;1. Enrollee continues to meet medical necessity criteria for this level of care.</td>
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<td>Services will be provided only in Florida counties where a recipient’s services council or local government entity exists that funds these services. Currently, this includes the following counties: Broward, Duval, Hillsborough, Martin, Miami-Dade, Palm Beach, and Pinellas</td>
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<td><strong>Children’s Services Council (CSC) and Local Government Entity (LGE)</strong>&lt;br&gt;The CSCs and LGEs, in conjunction with the Agency for Health Care Administration (AHCA), determine the TCM for children at risk of abuse and neglect certification criteria.&lt;br&gt;The designated CSC or LGE must approve, certify, and contract with the provider agency for the TCM for the children at risk of abuse and neglect target group.&lt;br&gt;The provider agency will continue to be certified as long as the provider agency continues to maintain its contract with the CSC or LGE and meet the certification criteria. If a provider loses its contract with the CSC or LGE, the provider is no longer eligible to provide services. This will result in termination of enrollment as a TCM provider agency for children at risk of abuse and neglect.</td>
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<td>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:</td>
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<td>f. Consistently attending scheduled therapy sessions/Case Management meetings,</td>
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<td>g. Family and community integration,</td>
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<td>h. Vocational/educational participation,</td>
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<td>i. Reduced hospital lengths of stay or child out-of-home placement,</td>
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<td>j. Reduced use of crisis-only services.</td>
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<td>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.</td>
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<td>4. Techniques employed in Case Management are time limited in nature and subordinate to a goal of enhanced enrollee autonomy.</td>
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<td><strong>Exclusion Criteria</strong> (Any one of the following):</td>
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<td>5. Enrollee or enrollee’s representative does not accept Targeted Case Management (TCM).</td>
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<td>6. TCM is not endorsed by the enrollee’s primary mental health providers.</td>
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<td>7. Enrollee does not meet the Admission guidelines for TCM.</td>
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<td>8. Enrollee requires services of a higher intensity (e.g., residential treatment).</td>
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<td>5. Diagnosis of primary substance disorder or developmental disability disorder.</td>
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<td><strong>Discharge Criteria</strong> (Must meet 1 and 2)</td>
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<td>3. Enrollee no longer meets continued stay criteria.</td>
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<td>4. A discharge plan had been developed including:</td>
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<td>c. A recommended aftercare plan which contains the signature of the enrollee, the family, involved others, and</td>
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<tr>
<td>d. A transition session is scheduled with the aftercare interagency team</td>
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**Psychological testing** is defined as the use of one or more standardized measurements, instruments or procedures to observe or record human behavior, and requires the application of appropriate normative data for interpretation or classification. Psychological testing may be used to guide differential diagnosis in the treatment of psychiatric disorders and disabilities. Testing may also be used to provide an assessment of cognitive and intellectual abilities, personality and emotional characteristics, and neuropsychological functioning.

Testing may be completed at the onset of treatment to assist in the differential diagnosis and/or help resolve specific treatment planning questions. It also may occur later in treatment if the individual’s condition has not progressed and there is no clear explanation for the lack of improvement.

**Service Components**

1. Prior to psychological testing, the individual must be assessed by a qualified behavioral health care 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.

2. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, administers the tests.

3. Requested tests must be valid and reliable in order to answer the specific clinical question for the specific population under consideration, and the most recent version of the test must be used. The instrument must be age-appropriate and meet the individual's developmental, linguistic, and cultural requirements.

**Criteria for Authorization:**

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for authorization:

**I. Severity of Need**

Criteria 1, 2, and 3 must be met:

1. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.

2. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.

3. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment.

**II. Intensity and Quality of Care**

Criteria 1 and 2 must be met:

1. 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.

2. 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.

**Continued Stay Criteria**

N/A

**Exclusion Criteria**

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

1. The testing is primarily for educational or vocational purposes.

2. The testing is primarily for the purpose of determining if an individual is a candidate for a specific medication or dosage.

3. 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.

4. The testing results could be invalid due to the influence of a substance, substance abuse, substance withdrawal, or any situation that would preclude valid psychological
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<td>testing results from being obtained (e.g., an individual who is uncooperative or lacks the ability to comprehend the necessary directions for having psychological testing administered).</td>
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<td>5. The testing is primarily for diagnosing attention-deficit hyperactive disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.</td>
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<td>6. Two or more tests are requested that measure the same functional domain.</td>
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<td>7. Testing is primarily for forensic (legal) purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing, or testing that is requested by an administrative body (e.g., a licensing board, Worker’s Compensation, or criminal or civil litigation).</td>
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<td>8. Requested tests are experimental, antiquated, or not validated.</td>
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<td>9. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.</td>
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<td>10. The testing is primarily to determine the extent or type of neurological impairment as potentially related to a plan of remediation or treatment, unless allowed by the individual’s benefit plan.</td>
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<td>11. 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.</td>
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<td>12. Structured interview tools that do not have psychometric properties or normative comparisons.</td>
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**Discharge Criteria:**

N/A
### XIV. DOWNWARD SUBSTITUTION (ALTERNATE SERVICES)

#### a. Adult In-Home Therapy (H2019 HB)

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<td>Adult In-Home Therapy includes rehabilitative and supportive counseling in the enrollee’s home. Travel time to the member’s location is not covered.</td>
<td><strong>Documentation must indicate that this level of care is being utilized as a downward substitution.</strong>&lt;br&gt;<strong>Admission Service Components (Must meet all of the following)</strong>&lt;br&gt;1. Professional staff.&lt;br&gt;   A. Must be licensed or certified at the independent practice level.&lt;br&gt;   B. If unlicensed must be supervised at least weekly by an appropriately licensed professional; all documentation should be counter-signed by the licensed supervisor.&lt;br&gt;   C. Services provided must be within the therapist’s scope of training and license.&lt;br&gt;2. Complete biopsychosocial assessment including, but not limited to the enrollee’s relevant history, previous treatment, current medical conditions (including medications), substance abuse history, lethality assessment and a complete Mental Status Exam.&lt;br&gt;3. Development of an individualized, strengths-based, targeted, focused treatment plan directed toward the reduction or alleviation of the impairment that resulted in the enrollee seeking treatment. The plan must reflect the least restrictive, most efficacious treatment available.&lt;br&gt;4. Development of specific, achievable, behaviorally based and objective treatment goals which directly address the problems that resulted in the enrollee seeking treatment.&lt;br&gt;<strong>Continued Stay Service Components - (Must meet all of the following)</strong>&lt;br&gt;1. Initial treatment plan has been formulated and is in the process of implementation.</td>
<td><strong>Admission Criteria (Must meet all of the following)</strong>&lt;br&gt;1. Validated principal DSM-5 diagnosis as part of a complete diagnostic evaluation.&lt;br&gt;2. Level of Stability - <em>(Must meet all of the following)</em>&lt;br&gt;   a. Risk to self, others or property is not imminent (although without treatment the enrollee’s potential risk in these areas may be increased).&lt;br&gt;   b. The enrollee is medically stable and does not require a level of care that includes more intensive medical monitoring.&lt;br&gt;   c. Treatment is directed to the acute symptoms which place enrollee at risk and/or impair functioning.&lt;br&gt;3. Degree of Impairment – <em>(Must meet at least one of the following)</em>:&lt;br&gt;   a. Enrollee exhibits impairments in cognitive, affective, or behavioral abilities.&lt;br&gt;   b. Social/Interpersonal/Familial-- Enrollee exhibits impairment in social, interpersonal or familial functioning arising from a psychiatric disorder or a serious emotional disturbance which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.&lt;br&gt;   c. Vocational/Educational-Enrollee exhibits impairment in occupation or educational functioning arising from a psychiatric disorder or a serious emotional disturbance which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.</td>
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<tr>
<td>1. Service Description and Common Service Settings</td>
<td>Active and timely treatment is focused upon stabilizing or reversing symptoms which necessitated outpatient treatment.</td>
<td>his/her likely level of functioning.</td>
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<tr>
<td>2. Active and timely treatment is focused upon stabilizing or reversing symptoms which necessitated outpatient treatment.</td>
<td>3. Level of intervention is consistent with current enrollee risk factors for harm to self, others or property.</td>
<td>3. Enrollee is making progress to the extent possible, toward goals and is benefiting from the treatment plan, as evidenced by the attainment of therapeutic rapport, lessening of symptoms and stabilization of psycho-social functioning through treatment planning, homework and session attendance.</td>
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<tr>
<td>3. Level of intervention is consistent with current enrollee risk factors for harm to self, others or property.</td>
<td>4. Treatment plan has been modified to reflect enrollee's progress and/or new information that has become available during the outpatient treatment.</td>
<td>4. As age appropriate, treatment promotes the enrollee's self-efficacy and independent functioning.</td>
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<tr>
<td>4. Treatment plan has been modified to reflect enrollee's progress and/or new information that has become available during the outpatient treatment.</td>
<td>5. Routine assessments and treatment progress updates are completed.</td>
<td>5. Current symptoms significantly impair the enrollee's ability to perform activities of daily living or significantly impair the enrollee's social, occupational or interpersonal functioning.</td>
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<tr>
<td>5. Routine assessments and treatment progress updates are completed.</td>
<td>6. Enrollee and family, to the extent possible and as clinically appropriate, are involved in treatment and discharge planning.</td>
<td>6. There is reasonable expectation, based on the enrollee's clinical history that withdrawal of treatment will result in the enrollee's decompensation or the recurrence of signs or symptoms.</td>
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<tr>
<td>6. Enrollee and family, to the extent possible and as clinically appropriate, are involved in treatment and discharge planning.</td>
<td>7. Natural community supports are identified.</td>
<td>7. Appearance of new problems which meet medical necessity for this level of care.</td>
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<td>7. Natural community supports are identified.</td>
<td><strong>Service Limits</strong></td>
<td><strong>Exclusion Criteria</strong></td>
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<td><strong>Service Limits</strong></td>
<td>1. 52 units (1 unit = 15 minutes) upon notification of the health plan.</td>
<td>1. Enrollee's condition has active components of significant risk to self or others or property such that a higher level of care is medically necessary.</td>
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<td>2. Prior Authorization required for additional units of up to 52 units upon meeting MNC. Limit of 4 units per day.</td>
<td>3. Appearance of new problems which meet medical necessity for this level of care.</td>
<td><strong>Discharge Criteria</strong></td>
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<td>3. Notification is requested of the provider to better allow MCC to maximize care coordination and collaboration of services on behalf of the member and allows MCC to rapidly identify members whose Serious Mental Illness could pose barriers to receiving the recommended treatments and support. Notification is not tied to payment of services.</td>
<td>(Any one of the following):</td>
<td>(Any one of the following):</td>
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<td>4. As age appropriate, treatment promotes the enrollee's self-efficacy and independent functioning.</td>
<td>1. Enrollee no longer meets continued stay medical necessity criteria.</td>
<td>1. Enrollee no longer meets continued stay medical necessity criteria.</td>
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<td>5. Current symptoms significantly impair the enrollee's ability to perform activities of daily living or significantly impair the enrollee's social, occupational or interpersonal functioning.</td>
<td>2. Enrollee withdraws from treatment against medical advice.</td>
<td>2. Enrollee withdraws from treatment against medical advice.</td>
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### b. Ambulatory Setting Substance Abuse Treatment and Detoxification Service (S9475)

#### i. Adult

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| The ambulatory detoxification service includes clinical and medical management of the physical and psychological process of withdrawal from alcohol and other drugs on an outpatient basis in a community based setting. This service is intended to stabilize the recipient physically and psychologically using accepted detox protocols. **Common settings:** Licensed ambulatory detoxification facility. | - Prior Authorization is required  
- Service Limits: 3 hours per day up to 30 days.  
- Unit of Service: Per Diem  
- Medical Necessity Criteria: ASAM Level 1-WM | **Admission Criteria:**  
The patient who is appropriately admitted is assessed as meeting specifications in ALL of the following six dimensions:  

**Dimension 1: Acute Intoxication and/or Withdrawal Potential**  
a. The patient is experiencing at least mild signs and symptoms of withdrawal, or there is evidence (based on history of substance abuse intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The patient is assessed as being at minimal risk for severe withdrawal syndrome and can be safely managed at this level; **and**  
b. The patient has withdrawal symptoms but is at minimal risk of severe withdrawal syndrome and is assessed as likely to complete needed withdrawal management and enter into continued treatment or self-help recovery, as evidenced by meeting [1] or [2], or [3]:  
   1. The patient has an adequate understanding of ambulatory withdrawal management and has expressed commitment to enter such program; or  
   2. The patient has adequate support services to ensure commitment to completion of withdrawal management and entry into ongoing treatment or recovery; or  
   3. The patient is willing to accept recommendations for treatment (for example, to begin disulfiram, naltrexone or other medication once withdrawal has been managed, or to attend outpatient sessions or self-help groups).  

**and**  
c. For patients whose withdrawal symptoms are no more severe than those in section (a) and (b), the patient has, and responds positively to, emotional support and comfort, as evidenced by:  
   1. Decreased emotional symptoms at the close of the initial treatment session; and  
   2. The patient’s or support person’s ability to clearly understand instructions for care, and the presence of both the ability and resources to follow instructions.  

**Dimension 2: Biomedical Conditions and Complications**  
The patient’s status in Dimension 2 is characterized by biomedical conditions and problems, if any, that are sufficiently stable to permit participation in outpatient treatment. Examples include uncomplicated pregnancy or asymptomatic HIV disease.  

**Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications**  
The patient’s status in Dimension 3 is characterized by (a) or (b) and both (c) and (d):  
   a. The patient has no symptoms of a co-occurring mental disorder, or any symptoms are mild, stable, fully
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<td>related to a substance use or other addictive disorder, and not to interfere with the patient’s stability to focus on addiction treatment issues; or</td>
<td>b. The patient’s psychiatric symptoms (such as anxiety, guilt, or thought disorders) are mild, mostly stable, and primarily related to either a substance use or other addictive disorder, or to a co-occurring cognitive, emotional, or behavioral condition. Mental health monitoring is needed to maintain stable mood, cognition, and behavior. For example, fluctuations in mood only recently stabilized with medication, substance-induced depression that is resolving but still significant, or a patient with schizophrenic disorder recently released from the hospital; and</td>
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<td>c. The patient’s mental status does not preclude his or her ability to (1) understand the information presented and (2) participate in treatment planning and the treatment process; and</td>
<td>d. The patient is assessed as not posing a risk of harm to self or others is not vulnerable to victimization by another.</td>
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**Co-occurring Enhanced Programs**

In addition to the above criteria, the patient’s status in Dimension 3 is characterized by either (a) or all of (b) and (c) and (d):

a. The patient has severe and chronic mental illness that impairs his or her ability to follow through consistently with mental health appointments and psychotropic medication. However, the patient has the ability to access services such as assertive community treatment and intensive case management or supportive living designed to help the patient remain engaged in treatment; or

b. The patient has a severe and chronic mental disorder or other emotional, behavioral, or cognitive problems, or substance-induced disorder; and

c. The patient’s mental health functioning is such that he or she has impaired ability to: (1) understand the information presented, and (2) participate in treatment planning and the treatment process. Mental Health management is required to stabilize mood, cognition, and behavior; and

d. The patient is assessed as not posing a risk of harm to self or others is not vulnerable to victimization by another.

**Dimension 4: Readiness to Change**

The patient’s status in Dimension 4 is characterized by (a); and one of (b) or (c) or (d):

a. The patient expresses willingness to participate in treatment planning and to attend all scheduled activities mutually agreed upon in the treatment plan; and

b. The patient acknowledges that he or she has a substance-related or other addictive disorder and/or mental health problem and wants help to change; or

c. The patient is ambivalent about a substance-related or other addictive disorder and/or mental health condition. He or she requires monitoring strategies, but not a structured milieu program. For example: (a) the patient has sufficient awareness and recognition of a substance use or addictive disorder and/or mental health problems to allow engagement and follow through with attendance at intermittent treatment sessions as scheduled; (b) the patient acknowledges that he or she has a substance-related and/or negative consequences and is in need of monitoring and motivating strategies to engage in treatment and progress through stages of change; or
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<td>d. The patient may not recognize that he or she has a substance-related or other addictive disorder and/or mental health problem. For example, he or she is more invested in avoiding a negative consequence than in recovery effort. Such a patient may require monitoring and motivating strategies to engage in treatment and to progress through stages of change.</td>
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**Dimension 5: Relapse, Continued Use, or Continued Problem Potential**

In Dimension 5, the patient is assessed as able to achieve or maintain abstinence and related recovery goals. Or the patient is able to achieve awareness of a substance or other addiction problem and related motivational enhancement goals, only with support and scheduled therapeutic contact. This is to assist him or her in dealing with issues that include (but are not limited to) concern or ambivalence about preoccupation with alcohol, tobacco, and/or other drug use; other addictive behavior; cravings to use or gamble; peer pressure; and lifestyle and attitude changes.

**Co-Occurring Enhanced Programs**

In addition to the above criteria, the patient is assessed as able to achieve or maintain mental health functioning and related goals only with support and scheduled therapeutic contact to assist him or her in dealing with issues that include (but are not limited to) impulses to harm self or others and difficulty in coping with his or her affects, impulses, or cognition.

While such impulses and difficulty in coping may apply to patients in both co-occurring capable and co-occurring enhanced program, patient in need of co-occurring enhanced program services are more unstable and require the outreach and support of assertive community treatment and intensive case management to maintain their mental health function. For example, such a patient may be unable to reliably keep mental health appointments because of instability in cognition, behavior, or mood.

**DIMENSION 6: Recovery Environment**

The patient’s status in Dimension 6 is characterized by (a) or (b) or (c):

a. The patient’s psychosocial environment is sufficiently supportive that outpatient treatment is feasible (for example, significant others are in agreement with the recovery effort; there is a supportive work environment or legal coercion; adequate transportation to the program is available; and support meeting locations and non-alcohol/drug-centered work are near the home environment and accessible).

or

b. The patient does not have an adequate primary or social support system, but he or she has demonstrated motivation and willingness to obtain such a support system;

or

c. The patient’s family, guardian, or significant others are supportive but require professional interventions to improve the patient’s chance of treatment success and recovery. Such interventions may involve assistance in limit-setting, communication skills, a reduction in rescuing behaviors, and the like.

**Co-Occurring Enhanced Programs**

In addition to the above criteria, the patient’s status in Dimension 6 is characterized by (a) or (b) or (c):

a. The patient does not have an adequate primary or social support system and has mild impairment in his or her ability to obtain a support system. For example, mood, cognition, and impulse control fluctuate and distract the patient from focusing on treatment tasks;
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<td>or</td>
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<td>b. The family, guardian, or significant others require active family therapy or systems interventions to improve the patient’s chances of treatment success and recovery. These may include family enmeshment issues, significant guilt or anxiety, or passivity or disengaged aloofness or neglect; or</td>
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<td>or</td>
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<td>c. The patient’s status in Dimension 6 is characterized by all of the following: (1) the patient has severe and chronic mental disorder or an emotional, behavioral, or cognitive condition, and (2) the patient does not have an adequate family or social support system, and (3) the patient is chronically impaired, but not in imminent danger, and has limited ability to establish a supportive recovery environment. However, he or she does not have access to intensive outreach and case management services that can provide structure and allow him or her to work toward stabilizing both the substance use or other addictive disorder and mental disorders.</td>
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Continued Stay
The patient continues to meet admission criteria. As the patient moves through treatment in any level of service, his or her progress in all six dimensions should be formally assessed at regular intervals relevant to the patient’s severity of illness and level of function, and the intensity of service and level of care.
## ii. Adolescent Service Description and Common Service Settings

### Magellan Specifications
- Prior Authorization is required
- Service Limits: 3 hours per day up to 30 days.
- Unit of Service: Per Diem
- Medical Necessity Criteria: ASAM Level 1-WM

Documentation must be sufficient to indicate that the enrollee meets clinical criteria for this level of care. The enrollee must meet criteria for detoxification.

**Documentation must indicate that this level of care is being utilized as a downward substitution.**

### Magellan Utilization Management Guidelines

**Adolescent Diagnostic Admission Criteria**

The adolescent who is appropriately placed in a Level 1 program is assessed as meeting the diagnostic criteria for substance use, substance-induced, and/or other addictive disorder as defined in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

If the adolescent's presenting alcohol, tobacco, and/or other use or addictive behavior history is adequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information obtained from collateral parties (such as family members, legal guardians, and significant others) when there is valid authorization to obtain this information.

The adolescent who is appropriately admitted to Level 1 is assessed as meeting specifications in all of the following six dimensions.

**DIMENSION 1: Acute Intoxication and/or Withdrawal Potential**

a. The adolescent is experiencing at least mild signs and symptoms of withdrawal, or there is evidence (based on history of substance abuse intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The adolescent is assessed as being at minimal risk for severe withdrawal syndrome and can be safely managed at this level;

b. The adolescent has withdrawal symptoms but is at minimal risk of severe withdrawal syndrome and is assessed as likely to complete needed withdrawal management and enter into continued treatment or self-help recovery, as evidenced by meeting [1] or [2], or [3]:
   1. The adolescent has an adequate understanding of ambulatory withdrawal management and has expressed commitment to enter such program; or
   2. The adolescent has adequate support services to ensure commitment to completion of withdrawal management and entry into ongoing treatment or recovery; or
   3. The adolescent is willing to accept recommendations for treatment (for example, to begin disulfiram, naltrexone or other medication once withdrawal has been managed, or to attend outpatient sessions or self-help groups).

c. For adolescents whose withdrawal symptoms are no more severe than those in section (a) and (b), the adolescent has, and responds positively to, emotional support and comfort, as evidenced by:
   1. Decreased emotional symptoms at the close of the initial treatment session; and
   2. The adolescent’s or support person’s ability to clearly understand instructions for care, and the presence of both the ability and resources to follow instructions.

**NOTE:** If the adolescent is presenting for treatment after recently experiencing an episode of acute withdrawal without treatment (as opposed to stepping down from a more intensive level of care...
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following a good response to treatment), it is safer to err on the side of greater intensity of services in making a placement. For example, a Level 2.1 setting may be indicated if the adolescent is doing poorly or if there are indicators for that level of care in other dimensions.

**DIMENSION 2: Biomedical Conditions and Complications**

The adolescent’s status in Dimension 2 is characterized by biomedical conditions and problems, if any, that are sufficiently stable to permit participation in outpatient treatment. Examples include uncomplicated pregnancy or asymptomatic HIV disease.

**DIMENSION 3: Emotional, Behavioral, or Cognitive Conditions and Complications**

The adolescent’s status in Dimension 3 is characterized by all of the following:

a. **Dangerousness/Lethality**: The adolescent is assessed as not posing a risk of harm to self or others. He or she has adequate impulse control to deal with any thoughts of harm to self or others.

b. **Interference with Addiction Recovery Efforts**: The adolescent’s emotional concerns relate to negative consequences and effects of addiction, and he or she is able to view them as part of addiction and recovery. Emotional, behavioral, or cognitive symptoms, if present appear to be related to substance-related problems rather than to a co-occurring psychiatric, emotional, or behavioral condition. If they are related to such a condition, appropriate additional psychiatric services are provided concurrent with the Level 1 treatment. The adolescent’s mental status does not preclude his or her ability to: (1) understand the materials presented (that is, his or her cognitive abilities are appropriate to the treatment modality and materials used); and (2) participate in the treatment process.

c. **Social Functioning**: Relationships or spheres of social functioning (such as with family, friends, and peers at school and work) are impaired but not endangered by substance abuse (for example, there is no imminent break-up of family, expulsion from home, or imminent failure at school). The adolescent is able to meet personal responsibilities and to maintain stable, meaningful relationships despite the mild symptoms experienced (such as mood swings without aggression or threats of danger, or in-school suspension for lateness but no suspensions for truancy).

d. **Ability for Self-Care**: The adolescent has adequate resources and skills to cope with emotional, behavioral, or cognitive problems, with some assistance. He or she has the support of a stable environment and is able to manage the activities of daily living (feeding, personal hygiene, grooming, and the like).

e. **Course of Illness**: The adolescent has only mild signs and symptoms. Any acute problems (such as severe depression, suicidality, aggression, or dangerous delinquent behaviors) have been well stabilized, and chronic problems are not serious enough to pose a high risk of vulnerability (such as chronic and stable low-lethality self-injurious behavior, chronic depression without significant impairment or increase in severity, or chronic stable threats without risk of aggression).

**DIMENSION 4: Readiness to Change**

The adolescent’s status in Dimension 4 is characterized by (a) and one of (b) or (c) or (d):

a. The adolescent expresses willingness to participate in treatment planning and to attend all scheduled activities mutually agreed upon in the treatment plan;
and

b. The adolescent acknowledges that he or she has a substance-related or other addictive disorder and/or mental health problem and wants help to change, but is ambivalent about recovery efforts and requires monitoring and motivating strategies;

or

c. The adolescent is ambivalent about a substance-related or other addictive disorder and/or mental health condition. He or she requires monitoring and motivating strategies, but not a structured milieu program. For example: (a) the adolescent has sufficient awareness and recognition of a substance use or addictive disorder and/or mental health problems to allow engagement and follow through with attendance at intermittent treatment sessions as scheduled; (b) The adolescent acknowledges that he or she has a substance-related and/or mental health problem but is ambivalent about change. He or she is invested in avoiding negative consequences and is in need of monitoring and motivating strategies to engage in treatment and progress through stages of change;

or

d. The adolescent may not recognize that he or she has a substance-related or other addictive disorder and/or mental health condition. For example, he or she is more invested in avoiding a negative consequence than in the recovery effort. Such an adolescent may require monitoring and motivating strategies to engage in treatment and progress through stages of change.

DIMENSION 5: Relapse, Continued Use, or Continued Problem Potential

In Dimension 5, the adolescent is assessed as able to achieve or maintain abstinence and recovery related goals. Or the adolescent is able to achieve awareness of a substance or other addiction problem and related motivational enhancement goals, only with support and scheduled therapeutic contact. This is to assist him or her in dealing with issues that include (but are not limited to) concern or ambivalence about preoccupation with alcohol, tobacco, and/or other drug use; other addictive behavior; cravings to use or gamble; peer pressure; and lifestyle and attitude changes.

DIMENSION 6: Recovery Environment

The adolescent's status in Dimension 6 is characterized by (a) or (b) or (c):

a. The adolescent's psychosocial environment is sufficiently supportive that outpatient treatment is feasible; for example, significant others are in agreement with the recovery effort; there is a supportive work environment or legal coercion; adequate transportation to the program is available; and support meeting locations and non-alcohol/drug-centered work are near the home environment and accessible);

Or

b. The adolescent does not have an adequate primary or social support system, but he or she
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<td>has demonstrated motivation and willingness to obtain such a support system; or</td>
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<tr>
<td>c. The adolescent's family, guardian, or significant others are supportive but require professional interventions to improve the adolescent's chance of treatment success and recovery. Such interventions may involve assistance in limit-setting, communication skills, a reduction in rescuing behaviors, and the like.</td>
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**Continued Stay**

The patient continues to meet admission criteria. As the patient moves through treatment in any level of service, his or her progress in all six dimensions should be formally assessed at regular intervals relevant to the patient’s severity of illness and level of function, and the intensity of service and level of care.
XV. OTHER SERVICES- PRIOR AUTHORIZATION NOT REQUIRED


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<tr>
<td><strong>Emergency Room Services</strong> are mental health treatment services provided by qualified mental health professionals that are available 24 hours/7 days per week and directed toward assessing and treating crisis situations of a clinical nature. These services are commonly provided in a hospital setting supervised by a licensed physician.</td>
<td>A psychiatric emergency is defined as an onset of a psychiatric condition that involves an immediate, substantial risk of serious harm to self, others or property, or an inability to maintain functioning in the community due to the DSM-5 diagnosis. For each mental health crisis, the goal is to intervene as early as possible to prevent the development of more serious problems. Emergency services must be under the supervision of a licensed physician and provide access to mental health specialists. The Emergency Department must have full medical services capable of assessing complicating medical conditions contributing to the behavioral crisis or serving as an etiological factor. Clinicians must be able to complete a biopsychosocial assessment including, but not limited to, the enrollee’s relevant history, previous treatment, current medical conditions (including medications), substance abuse history, lethality assessment and complete Mental Status Exam— all in the service of identifying the cause(s) of the mental health crisis. Clinicians must be able to involve the enrollee’s family in crisis resolution and be able to refer for inpatient admission if indicated.</td>
<td>There is no need for pre-authorization for emergency department services when the enrollee, family, support person, provider, etc. believe the situation to be a true behavioral emergency. Excluded are situations which are determined by the enrollee and/or enrollee’s family to be routine visits for convenience rather than true behavioral health emergencies.</td>
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<td><strong>Psychiatric Clinic</strong> and <strong>Psychiatric Visit/Individual Therapy</strong> include routine outpatient mental health services such as evaluation and assessment, individualized treatment planning, medication management, and individual counseling/therapy.</td>
<td>Specifications for these services may be found under IV. Community Mental Health Services</td>
<td>Utilization Management Guidelines for these services may be found under IV. Community Mental Health Services.</td>
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### b. Physician services- Adult and Child/Adolescent

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<td><strong>Physician services are rendered by a licensed physician with the appropriate Medicaid specialty requirements, when applicable. There are two types of physician services:</strong></td>
<td>The psychiatrist providing physician services must be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry or have completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada.</td>
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<td><strong>Psychiatric consultations (medical/surgical service, nursing home, etc.)</strong></td>
<td>A physician consultation must include a psychiatric examination (including the Mental Status Exam) and evaluation of the enrollee with information from family members or significant others as appropriate. Written documentation of an exchange of information with the attending physician and/or primary care physician must be included.</td>
<td>No preauthorization of service is required. Admission Criteria: Magellan uses its Mixed Services protocols to determine the process for claims payment of such consults. If the service is provided by a psychiatrist to treat a behavioral health disorder, then the protocols indicate that it is a Magellan managed service.</td>
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<td><strong>Inpatient psychiatric visit</strong></td>
<td>An inpatient psychiatric visit must be documented with a mental health procedure code and mental health diagnosis code. All procedures with a minimum time requirement must be documented in the medical record to show the time spent providing the service to the enrollee. Daily physician visits with documentation of such are required.</td>
<td>This service is allowed for one visit per day when inpatient services have been authorized. Admission, Continued Stay, Exclusion, and Discharge criteria are the same as for Inpatient Services.</td>
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### c. Community mental health services-Individual Treatment Plan Development and Modification, Evaluation and Assessment Services, Medical & Psychiatric – Adult and Child/Adolescent

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<td><strong>Individual Treatment Plan Development and Modification</strong> - Includes:</td>
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<td>No preauthorization is required for these services. Admission Criteria, Continued Stay Criteria, Discharge Criteria, and Exclusion Criteria shall be consistent with the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.</td>
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<td>- Treatment Plan Development – An individualized treatment plan is developed by using an assessment tool to create a structured, goal-oriented, schedule of services. This plan is developed by the enrollee and treatment team and contains attainable goals and measurable objectives. Prior to the development of a treatment plan the provider must complete and provide to the enrollee an assessment of mental health status, substance use concerns, functional capacity, strengths, and service needs or must have an assessment on file that has been conducted in the last six months. For enrollees under the age of 6 years, a comprehensive behavioral health assessment completed within the past year, may satisfy the current assessment requirement for services.</td>
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<td>- Treatment Plan Review – This process is used to make sure that treatment goals, objectives and services continue to be appropriate based on the enrollee’s progress. A formal review is conducted at least every six months or as needed, based on significant changes.</td>
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#### Treatment Plan Development

1. The treatment plan must be jointly developed by the enrollee and the treatment team. The treatment plan must be enrollee-centered and consistent with the enrollee’s identified strengths, abilities, needs, and preferences.

2. The enrollee’s parent, guardian, or legal custodian should be included in the development of the enrollee’s individualized treatment plan, if the enrollee is under the age of 18 years. Treatment planning for an enrollee under the age of 18 years that does not include the enrollee’s parent, guardian, or legal custodian in a situation of exception requires a documented explanation.

The treatment plan must contain all of the following components:

- The enrollee’s diagnosis code(s) consistent with assessment(s)
- Goals that are individualized, strength-based, and appropriate to the enrollee’s diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the enrollee
- Measurable objectives with target completion dates that are identified for each goal
- A list of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish a diagnosis and to gather information for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service for the six month duration of the treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms “as needed,” “p.r.n.,” or to state that the enrollee will receive a service “x to y times per week”
- Dated signature of the enrollee
- Dated signature of the enrollee’s parent, guardian, or legal custodian (if the enrollee is under the age of 18 years)
- Signatures of the treatment team members who participated in development of the plan
- A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the enrollee’s diagnosis and needs
- Discharge criteria
1. The treatment plan review is a process conducted by the treatment team to ensure that treatment goals, objectives, and services continue to be appropriate to the enrollee’s needs and to assess the enrollee’s progress and continued need for services. The treatment plan review requires the participation of the enrollee and the treatment team identified in the enrollee’s individualized treatment plan as responsible for addressing the treatment needs of the enrollee.

2. A formal review of the treatment plan must be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur in the enrollee’s clinical status.

### Evaluation and Assessment Services

- **Psychiatric Evaluation** – A psychiatric evaluation is a comprehensive evaluation that investigates the enrollee’s clinical status.
- The purpose of a psychiatric evaluation is to establish a therapeutic doctor–patient relationship, gather accurate data in order to formulate a diagnosis, and initiate an effective treatment plan.
- **Brief Behavioral Health Status Examination** – Brief clinical, psychiatric, diagnostic interview to assess behavioral stability or treatment status and must be completed prior to the development of the enrollee’s treatment plan.
- **Psychiatric Review of Records** – review of records includes psychiatric reports, psychometric or projective tests, clinical and psychological evaluation data for diagnostic use in evaluating and planning for enrollee care.
- **In-Depth Assessment** – diagnostic tool for collecting information to establish or support a diagnosis and development or modification to the treatment plan and discharge criteria.

### Evaluation and Assessment Services—Include:

- These services include psychological testing and evaluations that assess the enrollee’s functioning in all areas. All evaluations must be appropriate to the age, developmental level and functioning of the enrollee. All evaluations must include a clinical summary that integrates all the information gathered and identifies the enrollee’s needs. The evaluation should prioritize the clinical needs, evaluate the effectiveness of any prior treatment, and include recommendations for interventions and services to be provided to the enrollee.

8. Prior to receiving any community mental health services, children ages 0-5 must have: a current assessment (within one year) of presenting symptoms and behaviors; developmental and medical history; family, psychosocial and medical history; assessment of family functioning; a clinical interview with the primary caretaker and a observation of the enrollee’s interaction with the caretaker; and, an observation of the enrollee’s language, cognitive, sensory, motor, self-care, and social functioning.

The evaluation and assessment contains the following elements and must be provided (at a minimum) by the following clinicians:

1. Psychiatric evaluation—treating psychiatrist, treating physician, or psychiatric ARNP, or Psychiatric Physician Assistant (PPA)
2. Brief Behavioral Health Status Examination—licensed practitioner of the healing arts or master’s level certified addictions professional, Physician, or Psychiatrist.
3. Psychiatric Review of Records—psychiatrist, physician, PPA, or psychiatric ARNP.
4. In-Depth Assessment—Physician, Psychiatrist, Licensed Practitioner of the Healing Arts, Master’s level CAP, or master’s level practitioner.
5. Biopsychosocial Evaluation—Physician, Psychiatrist, Licensed Practitioner of the Healing Arts, Master’s level CAP, Master’s level practitioners, bachelor’s level practitioner or certified addictions professional.

No preauthorization is required for these services (excluding psychological testing).

Admission Criteria, Continued Stay Criteria, Discharge Criteria, and Exclusion Criteria shall be consistent with the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.
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<td>• Biopsychosocial Evaluation – provides information on biological, psychological and social factors that may have contributed to the enrollee’s need for services. The evaluation includes a brief Mental Status Exam and preliminary service recommendations.</td>
<td>6. Psychological Testing—psychologist or other individual practitioner with the scope of professional licensure, training, and competence and in accordance with applicable statutes.</td>
<td>See XII. Psychological Testing.</td>
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<td>• Psychosocial Testing – assessment, evaluation and diagnosis of the enrollee’s mental status or psychological condition through use of standardized testing methodologies.</td>
<td>7. Limited Functioning Assessment—individual who has been certified by DCF to administer the assessment. ASAM must be provided by an individual who has completed provider agency training.</td>
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<td>• Limited Functional Assessment – A limited functional assessment is restricted to administration of the Functional Assessment Rating Scale (FARS), and the Children's Functional Assessment Rating Scale (C-FARS), the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R), or any other functional assessment required by the Department of Children and Families (DCF).</td>
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<td>Medical and Psychiatric Services include the evaluation of the need for medication; evaluation of clinical effectiveness and side effects of medication; prescribing, dispensing, and administering of medications; medication education and facilitating informed consent; planning related to service delivery and evaluating the status of the enrollee’s community functioning.</td>
<td>1. Medication Management Medication management must be provided, at a minimum, by a psychiatrist, physician, physician assistant, PPA, or psychiatric ARNP.</td>
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<td>• Medication management includes the discussion of indications and contraindications for treatment, risks and management strategies based on the review of laboratory test results, prior pharmacy intervention and current medication usage with the enrollee or other responsible persons.</td>
<td>2. Brief Individual Medical Psychotherapy Brief individual medical psychotherapy must be provided, at a minimum, by a psychiatrist, physician, physician assistant, PPA, or psychiatric ARNP.</td>
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<td>3. Brief Group Medical Therapy Brief Group medical therapy must be personally rendered by a psychiatrist, physician, PPA, psychiatric nurse, or psychiatric ARNP. Total group size should not exceed 10 participants.</td>
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<td>4. Behavioral Health Related Medical Screening Service Behavioral health related medical screening services must be provided, at a minimum, by a psychiatrist, physician, PPA, physician assistant, psychiatric ARNP, psychiatric nurse, or registered nurse.</td>
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<td>No preauthorization is required for these services. Admission Criteria, Continued Stay Criteria, Discharge Criteria, and Exclusion Criteria shall be consistent with the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook. There are two parameters that guide Magellan’s authorization process for integrated services:</td>
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<td>• The suggested service must be linked to the mental health needs of the enrollee,</td>
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<td>• The service should complement and not conflict with the larger, mutually agreed-upon, person-centered recovery treatment plan that helps the enrollee live successfully in his or her home or</td>
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<td>• Brief Individual Medical Psychotherapy includes insight-oriented, cognitive-behavioral or supportive therapy treatment designed to reduce maladaptive behaviors related to the enrollee’s behavioral health disorder. This treatment is designed to maximize behavioral self control or to restore normal functioning and more appropriate interpersonal and social relationships.</td>
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<tr>
<td>• Brief Group Medical Therapy is designed to reduce maladaptive behaviors; maximize self control and restore normal functioning, enabling more appropriate interpersonal and social relationships. This service includes continuing medical diagnostic evaluation and medication management and may include insight-oriented, cognitive-behavioral and supportive therapy.</td>
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<td>• Behavioral Health Related Medical Screening Service includes a face-to-face assessment of the enrollee’s physical status and a brief history and decision-making of low complexity. The screening includes vital signs, medication concerns, a brief mental status assessment and a plan for follow-up, if necessary.</td>
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<td>• Behavioral Health Related Medical Services: Verbal Interactions are verbal interactions between a qualified medical professional and enrollee directly related to the enrollee’s behavioral health disorder to monitor side effects with medication.</td>
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<td>• Behavioral Health Related Medical Services: Medical Procedures are</td>
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<td>5. Behavioral Health Related Medical Services: Verbal Interactions</td>
<td>Behavioral Health Related Medical Services: Verbal interactions must be provider, at a minimum by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, registered nurse.</td>
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<tr>
<td>Behavioral Health Related Medical Services: Verbal interactions must be provider, at a minimum by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, registered nurse.</td>
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<tr>
<td>1. Behavioral Health Related Medical Services: Medical Procedures</td>
<td>Behavioral Health Related Medical Services must be provided at a minimum by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, registered nurse, licensed practical nurse, medical assistant.</td>
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<tr>
<td>Behavioral Health Related Medical Services must be provided at a minimum by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, registered nurse, licensed practical nurse, medical assistant.</td>
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<tr>
<td>2. Behavioral Health Related Medical Services: Alcohol and Other Drug Screening Specimen Collection</td>
<td>Behavioral Health Related Medical Services: Alcohol and Other Drug Screening Specimen Collection must be provided, at a minimum, by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, licensed practical nurse, medical assistant, LPHA, master's level CAP, master's level practitioner, CAP, bachelor's level practitioner, certified recovery peer specialist, certified psychiatric rehabilitation practitioner, certified behavioral health technician or substance abuse technician.</td>
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<tr>
<td>Behavioral Health Related Medical Services: Alcohol and Other Drug Screening Specimen Collection must be provided, at a minimum, by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, licensed practical nurse, medical assistant, LPHA, master's level CAP, master's level practitioner, CAP, bachelor's level practitioner, certified recovery peer specialist, certified psychiatric rehabilitation practitioner, certified behavioral health technician or substance abuse technician.</td>
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<tr>
<td>8. Behavioral Health Services</td>
<td>Specimen collection, taking vital signs, administering injections must be provided by an individual qualified by his/her professional licensure, training, protocols and competence and within the purview of statutes applicable to his/her profession. Verbal interaction must be provided, at a minimum, by a physician’s assistant, ARNP, or R.N.</td>
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<tr>
<td>Specimen collection, taking vital signs, administering injections must be provided by an individual qualified by his/her professional licensure, training, protocols and competence and within the purview of statutes applicable to his/her profession. Verbal interaction must be provided, at a minimum, by a physician’s assistant, ARNP, or R.N.</td>
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<td>9. Medication-Assisted Treatment</td>
<td>Medication-Assisted treatment must be provided under the supervision of a physician or a psychiatrist and must be provided by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, registered nurse licensed practical nurse, or medical assistant.</td>
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<tr>
<td>Medication-Assisted treatment must be provided under the supervision of a physician or a psychiatrist and must be provided by a physician, psychiatrist, PPA, physician assistant, psychiatric ARNP, ARNP, psychiatric nurse, registered nurse licensed practical nurse, or medical assistant.</td>
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activities of specimen collection, taking of vital signs, and administering injections related to the enrollee’s behavioral health disorder or to monitor side effects of psychotropic medications.

- **Behavioral Health Related Medical Services: Alcohol and Other Drug Screening Specimen Collection** are services covering specimen collection for the purposes of alcohol and other drug testing for the treatment of substance use disorders.

- **Medication-Assisted Treatment**—this service is reimbursed for the administration of methadone or buprenorphine for opioid addiction treatment by a program licensed by the state and certified by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) in accordance with state and federal guidelines.
**d. Comprehensive Behavioral Health Assessment (CBHA)**

### Service Description and Common Service Settings

Comprehensive Behavioral Health Assessment (CBHA) is an in-depth and detailed assessment of the enrollee’s emotional, social, behavioral and developmental functioning within the family home, school, and community. A CBHA must include direct observation of the enrollee in the home, school and community, as well as in the clinical setting.

**Goals of the CBHA:**

- Provide assessment of areas where no other information exists;
- Update pertinent information not considered to be current;
- Integrate and interpret all existing and new assessment information;
- Provide functional information, including strengths and needs, to the referral source, enrollee and family that will aid in the development of long and short-term, culturally sensitive intervention strategies to enable the enrollee to live and receive his or her education in the most inclusive environment;
- Provide specific information and recommendations to accomplish family preservation, re-unification, or re-entry and permanency planning;
- Provide date to promote the most appropriate out-of-home placement when necessary; and
- Provide information for development of an effective, individualized, strength based, culturally competent, comprehensive services plan and a Medicaid community behavioral health services individualized treatment plan, when indicated.

### Admission Service Components (Must meet all of the following)

1. CBHA group provider agencies and individual practitioners much complete a Comprehensive Behavioral Health Assessment Agency and Practitioner Self-Certification.
2. Prior to enrollment, an individual practitioner not currently enrolled in Florida Medicaid, much complete child and adolescent needs and strengths (CANS) assessment training, provided by a certified trainer or an approved online training course, and must obtain CANS certification.
3. Individual practitioners who meet the eligibility criteria to provide comprehensive behavioral health assessments must be linked to a certified comprehensive behavioral health assessment group provider agency before rendering this service.

### Admission Criteria (Must meet 1-2; or 3-5 ;)

In order to receive a CBHA, an enrollee must be 0-20 years of age and:

1. Be a victim of abuse or neglect; and
2. Have been determined by the Department of Children and Families district or regional Child Welfare or Community Based Care provider to require out-of-home care.

Or,

3. Have committed acts of juvenile delinquency; and
4. Be experiencing an emotional disturbance or serious emotional disturbance; and
5. Be at risk for placement in a residential setting.

### Continued Stay Criteria

N/A

### Exclusion Criteria

N/A

### Discharge Criteria

N/A
### e. Community mental health services- Mental Health Counseling/Therapy – Adult and Child/Adolescent

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| **Mental Health Counseling/Therapy** are treatment services provided by qualified mental health professionals that are directed toward ameliorating symptoms of a mental health disorder and/or maintaining stability and functional autonomy for enrollees with severe and persistent mental illness. Outpatient services are specific in targeting the symptoms or problem being treated. **Common Service Types:**  
- **Individual and family therapy services** include the provision of insight-oriented, cognitive behavioral or supportive therapy interventions to an individual recipient or a recipient's family. Individual and family therapy may involve the recipient, the recipient’s family without the recipient present, or a combination of therapy with the recipient and the recipient’s family. The focus or primary beneficiary of individual and family therapy services must always be the recipient.  
- **Group therapy services** include the provision of cognitive behavioral or supportive therapy interventions to an individual recipient or the recipient's family. In addition to counseling, group therapy services to recipient families or other responsible persons include educating, the sharing of clinical information, and guidance on how to assist the recipient. The group size is limited to 15 or less participants. |  |  |

**Admission Service Components (Must meet all of the following)**

1. Professional staff.  
   a. Must be licensed or certified at the independent practice level.  
   b. If unlicensed must be supervised at least weekly by an appropriately licensed professional; all documentation should be counter-signed by the licensed supervisor.  
   c. Services provided must be within the therapist's scope of training and license.

2. Complete biopsychosocial assessment including, but not limited to the enrollee’s relevant history, previous treatment, current medical conditions (including medications), substance abuse history, lethality assessment and a complete Mental Status Exam.

3. Development of an individualized, strengths-based, targeted, focused treatment plan directed toward the reduction or alleviation of the impairment that resulted in the enrollee seeking treatment. The plan must reflect the least restrictive, most efficacious treatment available.

4. Development of specific, achievable, behaviorally based and objective treatment goals which directly address the problems that resulted in the enrollee seeking treatment.

**Continued Stay Service Components - (Must meet all of the following)**

1. Initial treatment plan has been formulated and is in the process of implementation.

2. Active and timely treatment is focused upon stabilizing or reversing symptoms which

**Admission Criteria (Must meet all of the following)**

1. Validated principal DSM-5 diagnosis as part of a complete diagnostic evaluation.

2. Level of Stability - (Must meet all of the following)
   a. Risk to self, others or property is not imminent (although without treatment the enrollee’s potential risk in these areas may be increased).
   b. The enrollee is medically stable and does not require a level of care that includes more intensive medical monitoring.
   c. Treatment is directed to the acute symptoms which place enrollee at risk and/or impair functioning.

3. Degree of Impairment – (Must meet at least one of the following):
   a. Enrollee exhibits impairments in cognitive, affective, or behavioral abilities.
   b. Social/Interpersonal/Familial– Enrollee exhibits impairment in social, interpersonal or familial functioning arising from a psychiatric disorder or a serious emotional disturbance which may indicate a need for outpatient psychotherapy to stabilize of reverse the condition.
   c. Vocational/Educational-Enrollee exhibits impairment in occupation or educational functioning arising from a psychiatric disorder or a serious emotional disturbance which may indicate a need for outpatient psychotherapy to stabilize or reverse the condition.

**Continued Stay Criteria (Must meet 1 through 4, and either 5, 6, 7, or 8)**

1. Validated DSM-5 diagnosis with exacerbation, or definable and discrete active symptoms. Principal diagnosis must be accompanied by acute symptoms which are the focus of treatment.

2. There is a reasonable expectation that the enrollee will benefit from ongoing outpatient treatment.

   Benefit is defined as: demonstrated improvement in previous treatment as validated by objective tracking of progress toward treatment goals; and the enrollee's pre-morbid functioning suggests that he/she has not maximized his/her likely level of functioning.

3. Enrollee is making progress to the extent possible, toward goals and is
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<td>3. Level of intervention is consistent with current enrollee risk factors for harm to self, others or property.</td>
<td>necessitated outpatient treatment.</td>
<td>benefiting from the treatment plan, as evidenced by the attainment of therapeutic rapport, lessening of symptoms and stabilization of psycho-social functioning through treatment planning, homework and session attendance.</td>
</tr>
<tr>
<td>4. Treatment plan has been modified to reflect enrollee’s progress and/or new information that has become available during the outpatient treatment.</td>
<td>4. For children/adolescents, there is significant opportunity for family (including the enrollee) cooperation and involvement in the treatment process, except where the involvement of family members other than the enrollee would be clinically counter-productive or legally prohibited.</td>
<td>5. As age appropriate, treatment promotes the enrollee’s self-efficacy and independent functioning.</td>
</tr>
<tr>
<td>5. Routine assessments and treatment progress updates are completed.</td>
<td>6. Current symptoms significantly impair the enrollee’s ability to perform activities of daily living or significantly impair the enrollee’s social, occupational or interpersonal functioning.</td>
<td>6. As age appropriate, treatment promotes the enrollee’s self-efficacy and independent functioning.</td>
</tr>
<tr>
<td>6. Enrollee and family, to the extent possible and as clinically appropriate, are involved in treatment and discharge planning.</td>
<td>7. There is reasonable expectation, based on the enrollee’s clinical history that withdrawal of treatment will result in the enrollee’s decompensation or the recurrence of signs or symptoms.</td>
<td>7. As age appropriate, treatment promotes the enrollee’s self-efficacy and independent functioning.</td>
</tr>
<tr>
<td>7. Natural community supports are identified.</td>
<td>8. Appearance of new problems which meet medical necessity for this level of care.</td>
<td>8. Appearance of new problems which meet medical necessity for this level of care.</td>
</tr>
</tbody>
</table>

**Exclusion Criteria**

1. Enrollee’s condition has active components of significant risk to self or others or property such that a higher level of care is medically necessary.

**Discharge Criteria**

(Any one of the following):

1. Enrollee no longer meets continued stay medical necessity criteria.
2. Enrollee withdraws from treatment against medical advice.
### f. Community mental health services - Substance Abuse Services—Adult and Child/Adolescent

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<td><strong>Substance Abuse Services</strong>&lt;br&gt;Enrollees will receive Medicaid-funded substance abuse services through the fee-for-service system. Magellan care managers will use the Florida Supplement to the ASAM PPC-2R to assist enrollees in obtaining and locating needed services in this area.</td>
<td>Magellan will offer linkages to substance abuse providers and will coordinate and integrate care with mental health and substance abuse treatment. Coordination will be reflected in the Individualized Treatment Plan for enrollees with co-occurring disorders.</td>
<td>The Florida Supplement to the ASAM PPC-IIIR is used for the coordination of mental health treatment with substance abuse providers.</td>
</tr>
</tbody>
</table>
Peer Support interventions are collegial services delivered in the community such as the enrollee’s home or residence and/or community settings. The services are targeted toward the support of an enrollee with a serious and persistent mental illness. Such services are supportive and may be rehabilitative in focus and are initiated when there is a reasonable likelihood that such services will benefit the enrollee’s functioning and assist him/her in maintaining community tenure.

Examples:
- Person-to-Person Peer Support
- Telephonic Support
- Peer Supervision in community-based settings

Services may include: peer specialist activities, peer mentoring, peer education, recovery coach services and mental health services provided by peers. Does not include: paperwork for consumers, attendance at NAMI or other consumer support meetings, offering meeting space for consumer meetings, travel time or transportation of consumers, peer specialist time that is not spent on education or self-help activities, or other administrative services. Service can be held in the office or in the community.

<table>
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<tr>
<th>Service Components (Must meet all of the following)</th>
<th>Admission Criteria (Must meet all of the following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A peer support program will provide services directly by consumers of mental health services, including at a minimum:</td>
<td>1. Validated principal DSM-5 Diagnosis.</td>
</tr>
<tr>
<td>a. Adults eighteen and over who have been consumers of mental health services.</td>
<td>2. Level of Stability (Must meet a, b, c and d)</td>
</tr>
<tr>
<td>b. Adults who are presently stable regarding their mental illness.</td>
<td>a. Enrollee is presently under the psychiatric care of a board-eligible psychiatrist or other qualified physician.</td>
</tr>
<tr>
<td>c. Adults who have advanced in their mental health recovery plan and have been approved by their physician to perform this service.</td>
<td>b. Risk to self, others, or property is considered to be low. If risk to self, others, or property is present, it is determined that this can be managed by the current clinical team within the enrollee’s existing environment.</td>
</tr>
<tr>
<td>2. Services are directly supervised by mental health professionals who are licensed at the independent practice level. Services are provided by Magellan-credentialed organizational providers.</td>
<td>c. The enrollee is medically stable and does not require a level of care that includes more intensive medical monitoring. If not medically stable, then the enrollee has the necessary medical resources to medically stabilize.</td>
</tr>
<tr>
<td>a. An independently, Florida licensed mental health professional must be available by phone to Peer Support providers on a 24-hour basis.</td>
<td>d. Enrollee is accepting of this intervention.</td>
</tr>
<tr>
<td>b. A minimum of bi-weekly supervision meeting must be provided to Peer Support providers by licensed mental health professionals (Supervision must encompass mental health issues that affect those with a serious and persistent mental illness and substance abuse disorders.)</td>
<td></td>
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<tr>
<td>c. Supervision provided must be within the scope of practice and licensure for the mental health professional.</td>
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<tr>
<td>d. Peer support providers must have access to initial training of basic mental health</td>
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Continued Stay Criteria (Must meet 1 through 3)
1. Validated DSM-5 diagnosis.
2. There is a reasonable expectation that the enrollee will benefit from the Peer Support Program.
3. Enrollee continues to express a desire to continue with this intervention.

Exclusion Criteria (Any one of the following)
1. Expected benefits from this intervention can be provided by other resources available to the enrollee.
2. Recent history of aggression to others.
3. Diagnoses of primary substance disorder, antisocial disorder or developmental
symptomatology, crisis identification, mental health and psychosocial service systems and substance abuse identification.

e. Consumers providing Peer Support must have access to at least one hour per month of ongoing training from consumers who have experience in providing Peer Support. Consumers providing this training will be approved by Magellan.

3. Case loads will be kept at manageable levels to enhance the ability of Peer Support providers to interact with enrollees and provide support in an individualized manner.

4. A Peer Support program will appoint appropriate consumers to approve all management decisions regarding the design, deliver, and monitoring of Peer Support services.

5. A Peer Support program directly provides the following services in the home and community:
   a. Initiation of services upon approval of the enrollee’s psychiatrist or other mental health provider.
   b. Development of a Peer Support Specialist who can respond to those needs:
      - Support the needs of the enrollee
      - How the Peer Support Specialist can respond to those needs
      - Plan of coordination with present mental health and psychosocial service systems.
      - Safety plan that includes accessing community-based services for enrollees in crisis.

Service limits: 16 units per day (1 unit = 15 minutes). Prior Authorization not required.

4. Enrollee with symptoms/behaviors that may be manipulative or dangerous.

Discharge Criteria (Any one of the following)
1. Enrollee is no longer accepting services.
2. Enrollee has reached maximum benefit from these services.
3. Enrollee can receive adequate support from other sources.
### Service Description and Common Service Settings

Mobile Crisis are mobile assessment, referral, intervention, and triage services that can occur in any one of a number of settings. Such settings can include the consumer’s home, residential placement settings, outpatient clinics, foster homes, emergency rooms, inpatient medical units, etc.

Crisis Intervention services include intervention activities of less than 24-hour duration (within a 24-hour period) designed to stabilize a consumer in a psychiatric emergency. Should the mobile intervention be insufficient to stabilize the person, a determination will be made regarding the immediate initiation of a more intensive level of care.

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

Examples of providers of Mobile Crisis Intervention Mental Health Services include the following:
- mobile crisis team
- mobile counselors.

### Service Components

(Must meet all of the following)

**Service Components** (all of the following must be met)

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

**Service limits:** 96 units per year; maximum of 12 units per day (1 unit = 15 minutes)

Prior Authorization not required. Notification only: Notification is requested of the provider to better allow MCC to maximize care coordination and

### Admission Criteria

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

1. Level of Stability must meet a and b—
   a. the consumer presents a risk to self, others and/or property that may range from likely to imminent
   b. the immediate response is to conduct a thorough assessment of risk, mental status, psychosocial functioning, and medical stability, and, if necessary, to intervene immediately to de-escalate the crisis.

2. Degree of Impairment must meet a and b—
   a. the consumer has insufficient or severely limited resources or skills necessary to cope with the immediate crisis
   b. the consumer demonstrates impaired judgment and/or lack of impulse control and/or cognitive/perceptual abilities apparently arising from a psychiatric condition or chemical dependence.

### Continuing Stay Criteria

Crisis intervention services may be appropriate at various points in the consumer’s course of treatment and recovery. Each intervention, however, is intended to be a discreet, time-limited service (for example, less than 24 hours for crisis intervention) that stabilizes the consumer and moves him or her to the post-stabilization services, prior to returning to a more routine level of care.
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<td>collaboration of services on behalf of the member and allows MCC to rapidly identify members whose Serious Mental Illness could pose barriers to receiving the recommended treatments and support. Notification is not tied to payment of services.</td>
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