2013 FLORIDA MEDICAID LEVEL OF CARE GUIDELINES
LEVEL OF CARE: 23-HOUR CRISIS OBSERVATION

Description: The primary objective of this level of care is for prompt evaluation and or stabilization of participants presenting with acute psychiatric symptoms or distress. Duration of services may not exceed 23 hours, by which time stabilization and or determination of the appropriate level of care will be made. This service is to be provided in a secure and protected, medically staffed and psychiatrically supervised care environment.

Admission Criteria
- An indication of actual or potential danger to self as evidenced by severe suicidal intent or a recent attempt with continued intent as evidenced by the circumstances of the attempt, the participant’s statements, or extreme feelings of hopelessness and helplessness
- Indication of actual or potential danger to others as evident by a current threat.
- Loss of impulse control leading to life threatening behavior and /or psychiatric symptoms that require immediate stabilization in a structured, psychiatrically monitored treatment setting.
- The participant demonstrates a considerable incapacitating or debilitating disturbance in mood/thought/or behavior interfering with activities of daily living to the extent that immediate stabilization is required.
- Command auditory/visual hallucinations or delusions leading to suicidal and or homicidal intent.

Exclusions
- The participant can be safely treated in a less restrictive treatment setting.
- Threat/assaultive behavior is not accompanied by a psychiatric diagnosis.
- Presence of any condition of sufficient severity to require acute inpatient psychiatric treatment.
- The primary problem is social, economic or one of physical health without a concurrent major psychiatric episode meeting the criteria for this level of care.
- Admission is being used as an alternative to possible imprisonment.

Discharge Criteria
- Treatment goals and objectives have been substantially met.
- Length of stay at this level of care has surpassed the maximum 23-hour length of stay and a plan for continuation of services at another level of care has been established.
- Support systems allowing the participant to be maintained safely in a less restrictive treatment environment have been thoroughly explored and secured.
- The participant, family or guardian is competent but non-participatory in treatment or in following the program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite numerous attempts to address these issues.

LEVEL OF CARE: ASSESSMENT SERVICES

Description: a comprehensive evaluation that investigates the participant’s clinical status including the presenting problem, history of the present illness, previous psychiatric history, physical history, relevant personal,
and family history, personal strengths and a brief mental status exam. This examination concludes with a summary of findings, diagnostic formulation and treatment recommendations.

**Criteria**
- The evaluation should be conducted at the onset of illness or when the participant first presents for treatment.
- It may be utilized again if an extended treatment hiatus occurs, marked change in mental status occurs or admission or readmission to an inpatient setting.

**Exclusions**
- A psychiatric evaluation is not considered necessary when the participant has a previously established diagnosis of organic brain disorder unless there has been a change in mental status requiring an evaluation to rule out additional psychiatric processes that may respond favorably to treatment.
- A maximum of two psychiatric evaluations per participant per fiscal year.

**Services**
- H2000 HP comprehensive multidisciplinary evaluation/psychiatric evaluation by physician.

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**LEVEL OF CARE: LIMITED FUNCTIONAL ASSESSMENT**

**Description:** This assessment is restricted to the administration of the Multnomah Community Ability Scale (MCAS), Functional Assessment Rating Scale (FARS), and the Children’s Functional Assessment Rating Scale (C-FARS) or any other functional assessment required by the Department of Children and Families (DCF).

**Criteria**
- The assessment must be provided by an individual who has been authorized by DCF to administer the assessment.
- A copy of the assessment must be placed in the participant’s clinical record.
- This service does not require authorization in the treatment plan.

**Exclusions**
- Medicaid reimburses a maximum of 3 limited functional assessments per participant per fiscal year.

**Services**

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**LEVEL OF CARE: BRIEF BEHAVIORAL HEALTH STATUS EXAMINATION**

**Description:** A brief clinical, psychiatric, diagnostic, or evaluative interview to assess behavioral stability or treatment status.

**Criteria**
- Examination documentation must include the purpose of the exam, setting, mental status of the participant, findings, and plan.
- Must be provided, at a minimum, by a licensed practitioner of the healing arts or master’s level certified addictions professional.

**Exclusions**
- Medicaid reimburses a maximum of 10 quarter hour units annually, per participant, per fiscal year.
**LEVEL OF CARE: IN-DEPTH ASSESSMENT**

**Description**: A diagnostic tool for gathering information to establish or support a diagnosis, to provide the basis for the development of or modification to the treatment plan and the development of discharge criteria. The assessment must include an integrated summary. The summary is written to evaluate, integrate, and interpret from a broad perspective, history and assessment information collected. The summary identifies and prioritizes the participant’s service needs, establishes a diagnosis, provided and evaluation of the efficacy of past interventions, and helps to establish discharge criteria.

**Criteria**

- The participant must meet one of the following criteria to receive the assessment
  - The participant has a documented history of being in need of a level of treatment beyond outpatient individual or group therapy or medication management
  - The participant has been identified as high risk (step down from inpatient treatment)
  - The participant has been receiving intensive services for 6 months or longer and for whom the documentation supports a lack of significant progress
  - The participant has been identified through the utilization management process as being a high risk / high utilizer.
  - The participant is in the infants 0–5 age group and is reportedly exhibiting symptoms of an emotional or behavioral nature that is atypical for the child’s age and/or development.

**Exclusions**

- A master’s level practitioner must provide the assessment and integrated summary.
- Medicaid reimburses one in depth assessment, per participant, per fiscal year.

**Services**

- **H2010 HO** comprehensive multidisciplinary evaluation/brief behavioral health status exam.
- Substance abuse related services: H0001 HO, H0001 TS, H0001 HN, H0001, T1007, T1007 TS, T1023 HF, H0047 and T1015 HF

**LEVEL OF CARE: BIO-PSYCHOSOCIAL EVALUATION**

**Description**: The evaluation describes the biological, psychological and social factors that may have contributed to the participant’s need for services. The evaluation includes a brief mental status exam and preliminary service recommendations.

**Criteria**

- The evaluation must be reviewed, signed and dated by a master’s level practitioner or bachelor’s level certified addictions professional.
• The review must include clinical impressions, a provisional diagnosis and a statement by the reviewer that indicates concurrence or alternative recommendations regarding treatment.

**Exclusions**
- Medicaid reimburses 1 bio-psychosocial evaluation, per participant, per fiscal year.

**Services**
- **H0031 HN** mental health assessment bachelor degree/ bio-psychosocial evaluation, mental health.

**LEVEL OF CARE: REVIEW OF RECORDS (PSYCHIATRIC REVIEW)**

**Description:** Includes the review of participant records, psychiatric reports, psychometric / projective tests, clinical and psychological evaluation data for diagnostic use in evaluating and planning for the participant. A written report must be done by the individual rendering services and must be included in the participant’s medical record.

**Criteria**
- A psychiatrist or other physician, or psychiatric ARNP, at a minimum, must render psychiatric review of records.

**Exclusions**
- The review does not include a review of the provider agency’s own records except for psychological testing and other evaluations or evaluative data used to explicitly to address documented diagnostic questions.
- Medicaid reimburses a maximum of 2 psychiatric reviews of records, per participant, per fiscal year.

**Services**
- **H2000:** comprehensive multidisciplinary evaluation/psychiatric review of records.

**LEVEL OF CARE: PSYCHOLOGICAL TESTING**

**Description:** Assessment, evaluation, and diagnosis of the participant’s mental status or psychological condition through use of standardized testing materials

**Criteria**
A participant is eligible to receive psychological testing only under the following circumstances:

- At the onset of illness or suspected illness or when the participant first presents for treatment.
- Testing may be repeated if an extended hiatus in treatment or a marked change in status occurs.
- The participant is being considered for admission or readmission to an inpatient treatment program.
- There is documented difficulty determining a diagnosis or where there are divergent diagnostic impressions.
- To gather additional information to evaluate or redirect treatment efforts.
- A written report based upon test results must be done by the individual rendering services and must be included the participant’s medical record for all evaluation and testing services listed in the evaluation and testing section.
Exclusions

- Testing must be provided by an individual practitioner within the scope of professional licensure, training, protocols, and competence and in accordance with applicable statutes.

- Medicaid reimburses a maximum of 40 quarter hour units of psychological testing, per participant, per fiscal year.

Services

- H2019 therapeutic behavioral services, per 15 minutes/psychological testing.

LEVEL OF CARE: BRIEF INDIVIDUAL MEDICAL PSYCHOTHERAPY

Description: A treatment activity designed to reduce maladaptive behaviors related to the participant’s behavioral health disorder, to maximize behavioral self-control, or to restore normalized functioning and more appropriate interpersonal relationships. Includes insight oriented, cognitive behavioral or supportive therapy.

Criteria

- Therapy must be provided, at a minimum, by a psychiatrist, physician, physician assistant, or psychiatric ARNP.

Exclusions

- Medicaid reimburses a maximum of 16 quarter hour units, per participant, per fiscal year.

Services

- H2010 HE comprehensive medication services/brief individual medical psychotherapy, mental health
- H2010 HF comprehensive medication services/brief individual medical psychotherapy, substance abuse

LEVEL OF CARE: GROUP MEDICAL THERAPY

Description: A treatment activity designed to reduce maladaptive behaviors, maximize behavioral self control, or to restore normalized functioning, reality orientation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. This service includes continuing medical diagnostic evaluation and drug management, when indicated, and may include insight oriented, cognitive behavioral, or supportive therapy

Criteria

- Therapy must be personally rendered by a psychiatrist or psychiatric ARNP.

- Group therapy documentation must include the group topic, assessment of the group, level of participation, findings and plan.

Exclusions

- The size of the group can not exceed 10 participants.

- Medicaid reimburses a maximum of 18 quarter hour units of group medical therapy, per participant, per fiscal year.

Services

- H2010 HQ comprehensive medication services, group setting/group medical therapy

LEVEL OF CARE: BEHAVIORAL HEALTH SCREENING

Description: A face-to-face assessment of physical status, a brief history, and decision-making of low complexity.
Criteria
The assessment must include at a minimum:

- Vital signs.

- Medication concerns and possible side effects.

- Brief mental status assessment.

- Plan for follow up.

- The results of the examination must be included in the participant’s medical record.

- The service must be provided, at a minimum by a psychiatrist, physician, physician assistant, ARNP or registered nurse.

Exclusion
- Medicaid reimburses 2 behavioral health-screening services, per participant, per fiscal year.

Services
- T1023 HS: screening to determine appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol per encounter, mental health. Behavioral health screening.

- Substance abuse related services: H0001 HO, H0001 TS, H0001 HN, H0001, T1007, T1007 TS, T1023 HF, H0047 and T1015 HF

LEVEL OF CARE: BEHAVIORAL HEALTH SERVICES

Description: A verbal interaction (15-minute minimum between the provider and the participant. This service must be directly related to the participant’s behavioral health disorder or to monitoring side effects associated with medication (specimen collection, taking vitals, and administering injections)

Criteria
- Documentation for each service must describe the need and the participant’s interaction.

- Verbal interaction must be provided by a Physician’s assistant, ARNP or RN.

- The monitoring of possible medication side effects must be provided by an individual qualified by licensure, training, protocols and competence and within purview of statutes applicable to his/her profession.

Exclusion
- A behavioral health service is not reimbursable on the same day for the participant as behavioral health screening services.

Services
- H0046 mental health services not otherwise specified/behavioral health services, verbal interaction, mental health.

LEVEL OF CARE: CASE MANAGEMENT SERVICES

Description: Case management involves the accessing, linking, coordinating and monitoring of services aimed at assisting members in coping with psychosocial stressors. These services, provided by multiple providers, will enable the individual to participate fully in family and community activities. Instrumental to this coordination is the creation of an individualized care plan which reflects the participant’s strengths, personal goals, obtaining
individualized services, facilitating linkages to community based resources, and reviewing the progress made over the course of care.

**Admission Criteria**
- The participant meets at least one of the following requirements:
  1. Is awaiting admission to or has been discharged from a State mental Hospital.
  2. Has been discharged from a mental health residential treatment facility.
  3. Has had more than one admission to a crisis stabilization unit, short-term residential treatment facility, inpatient psychiatric unit, or any combination of these facilities within a 12-month period.
  4. Is at risk of institutionalization for mental health reasons.
  5. Is experiencing long-term or acute episodes of mental impairment that may put him/her at risk or requiring more intensive services.

- The participant presents with an axis I diagnosis or a behavioral condition associated with an axis II condition.

- The individual has a disability that requires advocacy for and coordination of services to maintain or improve level of functioning.

- Family/individual requires assistance with obtaining, coordination necessary treatment, rehabilitation and social services without which they would likely require a more restrictive level of care.

**Continued Care**
- The participant continues to meet criteria for case management services.

- The participant has made some progress toward more independent functioning, but evidences an ongoing inability to obtain or coordinate services without program support at this time.

**Exclusions**
- Ongoing services are for the primary purpose of providing support that can be obtained through other services or a lower level of care.

- The participant does not meet criteria for case management services.

- When dealing with a child the family refuses services and the child continues to live within the family home.

- The participant chooses to no longer participate in the program.

- Severity of symptoms requires a more intensive level of care/treatment intervention.

**Discharge Criteria**
- The participant no longer meets criteria for or requires program services.

- The individual/family are non participatory with the program.

- The participant requires a more restrictive level of care.

**Case Management**
- T1017 (TARGETED CASE MANAGEMENT FOR ADULTS).
- T1017HA (TARGETED CASE MANAGEMENT FOR CHILDREN BIRTH TO 17).
- T1017HK (INTENSIVE TEAM TARGETED CASE MANAGEMENT ADULTS).
**LEVEL OF CARE: CLUBHOUSE SERVICES**

**Description:** A place where people who have a mental illness come to rebuild their lives. Clubhouse services are structured, community-based group services provided in a group rehabilitation service setting. These services include a range of social, educational, pre-vocational and transitional employment. Every opportunity provided is the result of the efforts of the participant and staff who work together to achieve shared goals. These services are designed to assist the participant to eliminate the functional, interpersonal and environmental barriers created by their disabilities and to restore social skills for independent living and effective life management.

**Criteria**
- The participant must have a psychiatric diagnosis and be at least 16 years old.
- A referral from a psychiatrist, psychiatric ARNP, or licensed practitioner of the healing arts.
- A weekly progress note that describes what activities were performed to enhance/support the participant’s functioning.
- A monthly progress note at the end of each month that reflects how the services are linked to the goals and objectives of the participant’s treatment plan.
- Documentation describes the participant’s progress relative to the treatment plan.

**Exclusion**
- Medicaid reimburses services for a maximum of 1920 quarter hour units annually, per participant, per fiscal year.
- These units count against psychosocial rehabilitation units of service.

**Services**
- H2030 mental health clubhouse, per 15 minutes.

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**LEVEL OF CARE: PSYCHOSOCIAL REHABILITATION**

**Description:** Services combine daily medication use, independent living and social skills training, support to clients and their families, housing, pre-vocational and transitional employment rehabilitation training, social support and network enhancement, structured activities to restore participant to a higher level of functioning and diminish tendencies towards isolation and withdrawal. Services are intended to restore a participant’s skills and abilities essential for independent living. This differs from counseling/therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities.

**Criteria**
- Services are appropriate for participants exhibiting psychiatric, behavioral or cognitive symptoms or clinical conditions of sufficient severity to bring about a significant impairment in day to day personal, social, pre-vocational and educational functioning.
- The participant is diagnosed with a mental health disorder associated with psychiatric, behavioral or cognitive symptoms or clinical conditions of sufficient severity to bring about a significant impairment in functioning.
- Participation in psychosocial rehabilitation services is not solely for the purpose of satisfying legal requirements for treatment or services.
• Services rendered to participants will be designed to assist the recipient to compensate for or eliminate functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore skills for independent living and effective life management.

• Daily documentation describes what activities the rehabilitation counselor did to enhance/support the participant’s skills of daily life management.

• Monthly documentation reflects how the services are linked to the goals and objectives of the participant’s treatment plan, and describes the participant’s progress relative to the treatment plan.

**Exclusion**

• Medicaid reimburses a maximum of 1920 units of psychosocial rehabilitation services, per participant, per fiscal year.

• The participant has received behavioral health day services on the same day as psychosocial rehabilitation services.

• Based on the submitted clinical information by the rendering practitioner(s) and review by a board certified psychiatrist, the participant is not an appropriate candidate for services as evidenced by his/her inability to restore a higher level of functioning, or compensate for/eliminate functional deficits that are barriers for independent living. The provider has the opportunity to speak with the Medical Director to provide additional information as well.

• The participant’s sole purpose for participation in psychosocial rehabilitation services is to satisfy court/legal requirements.

• The participant does not have a valid Axis I mental health diagnosis as the primary purpose for treatment.

• The participant meets criteria for day treatment services, but participation in psychosocial rehabilitation services is unlikely to impact the participant’s ability to function more independently in the community.

• Despite an extended period of services at this level, the member has failed to make or sustain gains toward independent living and effective life management.

• These units count against clubhouse service units.

**Services**

• **H2017** psychosocial rehab services, per 15 minutes.

**LEVEL OF CARE: ADULT DAY TREATMENT**

**Description:** Provides a coordinated set of individualized therapeutic services to participants with psychiatric disorders who may be able to function only partially in a school, work, and or home environment and need the additional structured activities of this level of care. Active family involvement is important unless contraindicated. Frequency should be based upon individual needs. Day treatment is for participants who need more active or inclusive services than is typically available through traditional outpatient mental health services. Day treatment leads to the attainment of specific goals through detailed therapeutic interventions within a designated timeframe and allows for transitioning of the participant to an outpatient level of care and to other necessary supports, or other structured activities.

**Admission Criteria**

• The participant presents with symptoms associated with a diagnosis that requires and can be reasonably expected to respond to a therapeutic intervention.
Exacerbation or persistence of a longstanding psychiatric disorder results in symptoms of thought, mood, behavior or perception that significantly limit functioning.

Treatment planning should be individualized and specifically state what benefits the participant can reasonably expect to obtain. The participant requires structure for activities of daily living.

The participant is seen as able to master more intricate personal and interpersonal life skills.

**Continued Care**
- The participant's condition continues to meet admission criteria at this level of care and participant is actively involved in the plan of care and treatment activities.

- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are apparent.

- Care is rendered in a clinically appropriate manner and focused on the participant's behavioral and functional outcomes as indicated in the treatment plan.

- All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practices.

**Exclusions**
- The participant's condition requires placement in a more restrictive level of care due to an increase in symptoms or can be managed in a less restrictive level of care due to a decrease in the severity of symptoms.

- The primary focus is social, economic, or one of physical health without a concurrent psychiatric episode meeting criteria for this level of care.

- Admission is being used as an alternative to imprisonment.

**Discharge Criteria**
- The participant has been able to achieve stated treatment goals and thus no longer meets the admission criteria. Treatment can now be provided in a less intensive level of care.

- The participant has shown an increase in symptom severity and thus requires services which are beyond the scope of the current treatment option.

- Non-participation in treatment is of such a degree that treatment has been rendered ineffective or unsafe even with documented attempts to address this issue.

- The participant is not making progress towards obtaining treatment goals and there is no reasonable expectation of improvement at this level of care.

**Services**
- H2012 Behavioral health day treatment, per hour/day services mental health.
- H2012 HF Behavioral health day treatment, per hour/day services substance abuse.

**LEVEL OF CARE: CRISIS STABILIZATION**

**Description:** The most intensive level of psychiatric care. Twenty four hour skilled psychiatric nursing care, daily medical care, and a structured treatment milieu are required due to the participant's clinical presentation.
Typically, the individual poses a significant risk to self or others or shows severe psychosocial dysfunction.

**Admission Criteria**
The participant exhibits one of the following:
- The participant has attempted suicide or displays severe suicidal ideation with a specific plan of self-harm.
- Assaultive threats or behaviors, resulting from an axis I diagnosis, with clear risk of escalation.
- A recent history of violence resulting from an axis I or II diagnosis.
- Significant risk taking or poor impulse control resulting in danger to self or others.
- Command/bizarre behavior or psychomotor agitation or retardation that interferes with activities of daily living. These symptoms are of such a degree that the participant would not be able to function at a less intensive level of care.
- Disorientation or memory impairment which is due to an axis I diagnosis and endangers the wellbeing of the participant or others in the community.

**Exclusion Criteria**
- The participant can be safely maintained and treated in a less restrictive level of care.
- The participant exhibits serious and persistent mental illness and is not in an acute exacerbation of the illness. A member whose baseline functioning does not show any improvement.
- The primary problem is social, economic, or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care.
- Admission is being used as an alternative to imprisonment.

**Continued Care**
- The participant’s condition continues to meet admission criteria for inpatient care, acute treatment interventions have not been exhausted and no less restrictive level of care would be adequate.
- All services and treatment are carefully structured to achieve optimal results in the most time proficient manner possible consistent with sound clinical practices.
- The participant is active in the plan of care and treatment to the extent possible given the current psychiatric symptoms.
- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and or psychiatric/medical complications are evident.

**Discharge Criteria**
- Treatment goals and objectives have been substantially met or continuing care can be implemented in a less restrictive level of care.
- The participant, family of guardian is competent but non-participatory in treatment or in following program rules/regulations. The non-participant is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple attempts to address this issue.
- The participant is not making progress towards treatment goals and there is no reasonable expectation
LEVEL OF CARE: INTENSIVE CASE MANAGEMENT

Description: Intensive case management provides for the assignment of a single fixed point of accountability for the participant that ensures the coordination of services that will enable the participant to live in the least restrictive environment possible while increasing adaptive capabilities of the participants. Services include the development of a highly individualized and integrated care plan.

Admission Criteria
- The participant is enrolled in a Department of Children and Families adult mental health target population.
- The participant meets at least one of the following requirements:
  1. The participant has resided in a State Mental facility for at least 6 months in the past 36 months.
  2. The participant resides in the community and has had two or more admissions to a State Mental hospital in the past 36 months.
  3. The participant resides in the community and has had three or more admissions to a crisis stabilization unit (CSU), short-term residential facility, inpatient psychiatric unit, or any combination of these facilities in the past 12 months.
  4. The participant 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 a period of time were not provided.
- The participant can not be maintained in a less restrictive treatment setting without case management services.
- Individual/family requires assistance in obtaining and coordinating treatment, rehabilitation and social services, without which the participant would likely require a more restrictive level of care.

Continued Care
- The participant continues to meet criteria for this intensity of service.
- Behaviors and/or symptoms demonstrate the continued need for the service.
- Individual/family actively participates in the development and implementation of the treatment plan.
- Continued inability to obtain or coordinate services without program supports will lead to the need for more restrictive treatment in the absence of continued services.

Discharge Criteria
- The participant has demonstrated the ability to remain out of the hospital for 3 months and/or the ability to maintain adherence with treatment plan and consent of referring agency.
- The goals have been substantially met and the participant shows the ability to be able to access needed services/supports and sustain activities of daily living.
- The member can be treated at a lower level of care or least restrictive setting.

LEVEL OF CARE: MEDICATION MANAGEMENT

Description: The provision of a prescription, and ongoing medical monitoring. The sole service rendered by a qualified provider, is the evaluation of the need for psychotropic medication.
Admission Criteria
- There is a need for prescribing and monitoring of psychotropic medications.

Continued Care
- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
- All services and treatment are carefully structured to achieve optimal results in the most time efficient manner possible, consistent with sound clinical practices.

Discharge Criteria
- The participant no longer requires psychotropic medication.
- Consent for treatment has been withdrawn.
- Non-participation is of such degree that treatment at this level of care is rendered ineffective or unsafe, in spite of multiple attempts to address the non-compliance issues.

Services
- **T1015** clinic visit, all inclusive, medication management.

### LEVEL OF CARE: OUTPATIENT SERVICES

**Description:** Therapeutic services which are provided in an office, clinic setting, home or other location appropriate to the provision of psychotherapy or counseling. Services focus on the restoration, enhancement and /or maintenance of the participant’s level of functioning and the lessening of symptoms which significantly interfere with functioning in at least one are of the participant’s daily functioning. The goals, frequency and length of treatment will vary according to the needs of the participant and the response to treatment.

Treatment can be seen as falling into 1 of 3 possible categories based upon the clinical information.

1. **Situational:** This is usually a brief clinical intervention (1-10 sessions) which has as a focus the resolution of a current life crisis, or adjustment to an external stressor.

2. **Symptom Based:** This type of intervention can be of an intermediate duration (1-20 sessions) and is focused on the reduction of symptoms associated with an axis I or II diagnosis and may include psychopharmacological measures.

3. **Intricate:** This intervention is to be considered for participants who have tried less restrictive clinical interventions which has been unsuccessful in controlling symptom severity. This approach may require the use of longer term therapy and medication management. Schedules or intermittent contact with a treatment provider is necessary to maintain the participant’s current level of functioning and to prevent the possible need for more restrictive treatment interventions.

Admission Criteria
- The participant has a chronic mental illness (schizophrenia) or a refractory condition (personality disorder) which by history has required inpatient treatment.

- The participant shows symptoms which are consistent with an axis I diagnosis and can be reasonably expected to respond to therapeutic interventions. These symptoms are significant and interfere with the participant’s ability to function on a daily basis.
• The belief exists that the participant has the ability to make significant progress towards treatment goals or treatment is necessary to maintain the current level of functioning.

Continued Care
• Improvement in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.

• All services and treatment are carefully structured to achieve optimal results in the most time efficient manner possible consistent with established clinical practices.

Exclusions
• Treatment is designed to address goals other than relief of symptoms associated with an axis I or II diagnosis.

• The primary problem is social, educational, economic, one of physical health without concurrent major psychiatric episode meeting criteria for this level of care.

• Admission is being used as an alternative to imprisonment.

• The participant requires a level of care beyond the scope of current services.

Discharge Criteria
• The treatment goals/objective have been substantially met.

• Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple attempts to address this issue.

• The participant is not making progress towards treatment goals and there is no reasonable expectation of improvement at this level of care.

Services
• H2019 HQ therapeutic behavioral services, per 15 minutes, group setting/group therapy
• H2019 HR therapeutic behavioral services, per 15 minutes, family/couple with client present/individual and family therapy.

LEVEL OF CARE: TARGETED CASE MANAGEMENT

Description: Specialized case management is intended to be used in a wide variety of circumstances; short term intervention to transition a participant from one level of care to another. This form of case managed may also be used with participants and their families, who need temporary assistance obtaining services.

Admission Criteria
• The participant meets at least one of the following requirements:
  1. Has had more than one admission to a crisis stabilization unit, short-term residential treatment facility, inpatient psychiatric unit, or any combination of these facilities
  2. Is at risk of institutionalization for mental health reasons
  3. Is experiencing long-term or acute episodes of mental impairment that may put him/her at risk or requiring more intensive services
  4. Is experiencing apparent distress due to current environmental factors which require short-term intervention to transition the participant to a less restrictive level of care.

• The participant presents with an axis I diagnosis or a behavioral condition associated with an axis II
condition which is severe enough that, in the absence of intervention, the condition would require treatment at a more restrictive level.

- The individual has a disability that requires advocacy for and coordination of services to transition to a lower level of care.
- Family/individual requires assistance with obtaining, coordination necessary treatment, rehabilitation and social services without which they would likely require a more restrictive level of care.

**Continued Care**
- The participant continues to meet criteria for specialized case management services.
- The participant has made some progress toward more independent functioning, but evidences an ongoing inability to obtain or coordinate services without program support at this time.
- The treatment plan clearly defines the expected treatment goals and the time frame for achieving these specific activities.

**Exclusions**
- The participant has an axis I diagnosis which is not reasonably expected to improve or successfully respond to therapeutic interventions. The member is unable to show any positive improvement given their baseline behavior.
- Ongoing services are for the primary purpose of providing support which can be obtained through other services or a lower level of care.
- The participant does not meet criteria for specialized case management services.
- The participant can be effectively treated at a less restrictive level of care.

**Discharge Criteria**
- The goals of the care coordination have been successfully achieved.
- The participant can be treated a less restrictive level of care.

**LEVEL OF CARE: THERAPEUTIC BEHAVIORAL ON SITE SERVICES**

**Description:** An intensive family based treatment intervention that is delivered where the child is living, working, or participating in educational activities and designed to stabilize family functioning and preserve the safety of the child, family, community and maintaining the child within the home setting. Service components include comprehensive assessment of family structure, roles, and dynamics, crisis intervention, service coordination, and the teaching, accessing tangible resources and modeling of family skills. Intensity of treatment depends upon the clinical needs of the family unit.

**Admission Criteria**
- A member demonstrates psychological symptoms which are consistent with and axis I diagnosis and which requires, and is likely to respond to, therapeutic interventions.
- The identified participant and family have complex needs that in the absence of intervention at this level will require a more intensive, restrictive behavioral health placement.
- Family functioning is seriously disrupted and threatens the wellbeing of the individual, family, community, or continued in-home placement.
• The family has the ability and willingness to actively take part in this intervention.

• There are multiple systemic problems that require in-home intervention several hours a week and/or traditional, office based interventions have been ineffective in the stabilization of family functioning.

• The services are intended to maintain the child/adolescent in the home.

**Continued Care**

• Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address the lack of progress is evident.

• The participant continues to meet admission criteria and there is active planning for transition to a less restrictive level of care.

**Exclusions**

• Consent is not obtained for this intervention.

• The family is not willing to or does not have the ability to actively take part in this intervention.

• The home environment is not safe/stable enough to allow staff to appropriately intervene.

• The family based modification can be accomplished using a less restrictive intervention.

**Discharge Criteria**

The family is not making progress towards goals and there is no reasonable expectation of improvement at this level.

• The family no longer has the ability/willingness to participate in this intervention.

• Treatment goals have been substantially met.

• The participant can be effectively treated at a lower level of care.

• Despite an extended period of services at this level, the member has failed to make or sustain gains as delineated in the treatment objectives.

**Services for Children and Adolescents**

• **H2019 HM** therapeutic behavioral services, per 15 minutes/less than bachelor degree level/onsite services, behavior management.

• **H2019 HN** therapeutic behavioral services, per 15 minutes onsite services, behavior management.

• **H2019 HO** therapeutic behavioral services, per 15 minutes/masters level/onsite services, behavior management, per 15 minutes.

**LEVEL OF CARE: TREATMENT PLAN DEVELOPMENT AND MODIFICATION**

**Description:** A structured, goal directed schedule of services developed jointly by the participant and the treatment team. If the participant’s age or clinical condition preclude participant in the development of the plan an explanation must be provided. The plan must contain written treatment-related goals and measurable objectives.

**Criteria**

The treatment plan must contain the following elements:

• Specific diagnosis codes.
• Goals that are focused on the participant’s strengths and abilities.
• Measurable objectives and target dates.
• Services to be provided.
• Frequency of treatment interventions.
• An addendum may be used to make changes to the treatment plan in lieu of rewriting the entire plan.
• The addendum must be signed and dated by the treating practitioner and the participant.

Exclusion
• Medicaid reimburses 1 treatment plan development, per provider, per fiscal year with a maximum total of 2 per participant per fiscal year.

Services
• H0032 mental health service plan development by non-physician/treatment plan development, new and established patient mental health.

LEVEL OF CARE: TREATMENT PLAN REVIEW

Description: A process conducted to ensure that treatment goals, objectives and services continue to be appropriate to the participant’s needs and to assess the participant’s progress and continued need for services.

Criteria
• A formal review of the treatment plan must be conducted at least every 6 months. The plan may be reviewed more often when significant changes occur.

• During the plan review, activities, notations of discussions, findings, conclusions, and recommendations must be documented. The written documentation must be included in the participant’s medical record upon completion of the plan review activities.

• If the assessment indicates that the goals/objectives have not been met, documentation must reflect the treatment team’s re-assessment of services and justification if no changes were made.

Exclusion
• Medicaid reimburses a maximum of 4 plan reviews per participant per fiscal year

Services
• H0032 TS mental health service plan development by non-physician/treatment plan development, follow up service.
REFERENCES

1. Mental Health Targeted Case Management Coverage and Limitations Handbook, the Community Mental Health Services Coverage and Limitations Handbook (or herein, subsequently referred to as the Community Behavioral Health Services Coverage and Limitations Handbook, which was noticed in Volume 30, Number 40, October 1, 2004 of the Florida Administrative Weekly), consistent with section 10.1, and specific service requirements as described in the general service requirements of the Area 1 PMHP RFP, dated June 1, 2001.

2. 2009 – 2012 Florida Medicaid Contract, Section D.1 (a); Table 5 with “X” as specified in applicable exhibits to the attachment and as defined in Attachment II, Section I, Definitions; Section V, Covered Services; and Section VI, Behavioral Health Care, and as specified in applicable exhibits to Attachment I; and the Florida Medicaid Behavioral Health Services Coverage and Limitations Handbook