



JEFFERSON  
BEHAVIORAL  
HEALTH

Managed Mental Health Care Organization for Coos, Curry, Douglas, Jackson, Josephine, and Klamath Counties

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# CHILDREN'S MENTAL HEALTH SERVICES UTILIZATION AND RESOURCE MANAGEMENT PLANS

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**Effective July 1, 2008**

Utilization Management Plan Approved by the JBH Board of Directors on April 28, 2008

Resource Management Plan Approved by the JBH Board of Directors on May 28, 2008

## Revisions

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# Purpose, Objectives & Guiding Principles

## Purpose Statement

Jefferson Behavioral Health (JBH) shall provide age appropriate, medically necessary mental health services to children and adolescent members. The provision of treatment shall be active, individualized, and goal-focused, and address children's mental health diagnoses, symptoms, and functional capacities in such a way as to prepare them for less intensive levels of care. Children and adolescents will be treated in a family centered approach in the most normative, least restrictive setting for service delivery. The Utilization Management Plan establishes guidelines and Treatment parameters which may result in limitation being placed on covered services as allowed in the agreement between the State of Oregon and JBH. The Utilization Management Plan describes the criteria used by JBH in making Utilization Management decisions and decisions on appeals. The Utilization Management Plan is binding on JBH staff and County Care coordination staff who are involved in utilization management or resource management.

## Objectives

Care to all children and adolescents should be:<sup>1</sup>

1. **Safe** - provided in an environment that is adequately staffed and equipped to keep children and adolescents free from harm from self or others.
2. **Effective** - care provided to children and adolescents which produces a desired change in mental health symptoms or social functioning. To be effective the effect must be measured by both direction and amount of change toward meeting a goal. In the case of acute or short term conditions the goal is a return to the pre-morbid level of functioning/productivity. The goal for chronic illnesses is to attain the highest level of functioning and productivity possible. Effective treatment is correlated to the use of evidenced based clinical practices and the fidelity with which the practice is implemented.
3. **Family centered** – priority and choices of the family drive the delivery of services. At the heart of family centered care is the recognition that the family is the constant in the child or adolescents life. Family centered care is not a destination or a state of being but

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<sup>1</sup> Institute of Medicine: "Crossing the Quality Chasm", 2001 and "Improving the Quality of Mental Health and Substance Use Conditions," 2005.

pursuit of being responsive to the family needs, values, culture, language, priorities and choices.

4. **Timely – services are available when medically necessary and provided in medically appropriate time frames.**
5. **Efficient - used to mean the same as cost-effective. Care that produces the desired change (i.e. is effective) at the lowest cost.**
6. **Equitable** - care is distributed fairly and equally to children and adolescents regardless of geographic location, gender, ethnicity and social economic background.

### **Guiding Principles**

1. Care is optimal when systems are organized to coordinate and integrate services.
2. Coordination of services is essential for all children involved with more than one system; e.g. mental health, child welfare, juvenile justice, alcohol and drug, school.
3. Care is to be tailored to the individual needs and strengths of the child and family
4. Care should be delivered in the most community-based and least restrictive setting that meets the child and family needs.
5. Services are coordinated and integrated into a Comprehensive Services Coordination Plan.
6. Care should be delivered in a culturally competent way whenever clinically appropriate.
7. Families are to be included in all aspects of care and care planning.
8. Treatment services should focus on reduction of out-of home placements and service fragmentation.
9. Promotion of early intervention and prevention services to reduce functional morbidity.
10. Interventions should be designed to reinforce the strengths of the child and family and should be evidenced based.
11. Disengagement of services by child and/or family should trigger a review of the Comprehensive Service Coordination Plan rather than a discharge from care.

**Care Coordination:** A set of activities by which a system of care assures that every person served by the system has a single approved care or service plan that is coordinated, not duplicative and within prescribed parameters designed to assure cost effective and good outcomes. The purpose of care coordination is managing limited resources while ensuring the highest quality care possible. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older children to the adult service system.

**Case Management:** A clinical service focused on those individuals who are determined to need assistance with coordination of services; daily living skills; finding and maintaining housing, jobs and friends; and in some cases, a single long-term relationship with a professional caregiver or helper.

Case management includes: identifying strengths and needs; identifying, brokering and linking community services and resources; assisting in obtaining entitlements; advocating on behalf of children and families; providing support and consultation to families; facilitating access to intensive services; and providing crisis planning , prevention, and intervention services.

**Child and Family Team:** The locus of service planning and decision making for each child receiving service, especially for children receiving intensive service arrays. They are composed of the child, his or her family, and other family or friends chosen by the child and/or parents. In addition, the team should include the mental health provider(s) and any other agency providers that are involved with the child, such as schools, child welfare, religious organizations, etc. The child and family team should promote a climate of collaboration, respect, and trust. The team should meet on a regular basis.

**Continued Stay:** The diagnostic, behavioral, and functional indicators documented in the child's Comprehensive Services Coordination Plan that clearly show that the child should continue in the same level of care. These indicators are established by the interdisciplinary team, which provide the rationale for a child to remain in a level of care for the diagnosed mental health condition. These indicators must be available for regular external review for continued authorization.

**Community System of Care:** In broad terms, this is defined as comprising the wide array of child-serving agencies, programs, and practitioners in both public and private practice, in addition to natural community supports, such as religious and consumer organizations.

**Essential Treatment:** Treatment that is neither more nor less than what is clinically appropriate for the patient at a specific point in time.

**Intensive Community Based Treatment and Support Services – ICTS:** A specialized set of in-home and community based supports and mental health treatment services that are delivered in the most normative, least restrictive setting. ICTS includes, but is not limited to: crisis prevention and intervention; care coordination; case management; individual, group and family therapy; psychiatric services; skills training; family support and education; respite care; and team driven service coordination planning in a wraparound model of care.

**Level of Care or Intensity of Services:** The relative amount and intensity of mental health services provided from the least restrictive and least intensive in a community setting to the most restrictive and most intensive in an inpatient setting. As required by ORS 430.210(a), children are to receive service in the most normative, least restrictive, least intrusive level of care appropriate to their treatment history, degree of impairment, current symptoms, and the extent of family or other supports.

**Medically Necessary (Medical Necessity):** Medically Necessary services, as defined by the American Psychiatric Association, shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Services should be the most cost effective of the alternative levels of service which can be safely and effectively be provided to the child and family, as determined by the JBH UM staff or UM CERTIFICATE OF NEED team.

**Mentoring Services:** Services are provided as part of the wraparound package by a trained adult, who has a developed relationship with the child. This relationship should be of long duration and consist of regular contacts in which the child and mentor are engaged in normative social and recreational activities.

**Psychiatric Day Treatment:** Services for children who are living in the community with a parent, guardian or foster parent. Day treatment services are provided by qualified mental health professionals and qualified mental health associates in consultation with a psychiatrist and in coordination with educational needs of the child by certified teachers and aides. Day treatment is a level of care within the array of services available for children who require an intensive level of service for a serious mental health issue. Children can be referred by local school districts, providers, family members, or childcare/preschool programs. Admission and continued stay requirements must be met along with expectations of treatment.

**Psychiatric Residential Treatment (PRTS):** Services provided in a structured treatment environment with daily 24-hour supervision and active mental health treatment. PRTS are provided by nationally accredited providers certified by Oregon regulations to provide active treatment for children diagnosed with a mental disorder. Admission requirements and approval must be met for placement in this level of care.

**Strength-based Services:** This is a clinical approach in which the provider recognizes and utilizes the adaptive capacities of children and their families rather than primarily focusing on the pathology. These types of services enhance the child and/or family's adaptive strengths, build self-esteem, and provide opportunities for successful experiences.

**Utilization Management:** A combination of resource management and clinical decision making to make sure that services will be used appropriately, make a difference, and produce the best value possible. Utilization Management includes the tasks or duties included in Care Coordination and Case Management.

**Wraparound:** A process and not a service whereby care is individualized for each child and family. Services are based on the unique strengths and needs of the child and are an alternative or an addition to traditional services that are as likely or more likely to effectively treat a child's mental health condition. Services may include informal supports and resources, and are provided to a child and family member in order to promote, maintain, or restore successful community living. Services are delivered as a result of a collaborative planning process and are provided in a manner or place different from the traditional manner or place of service delivery. The wraparound process is an integrated assessment and planning process that results in this unique set of community services with the use of natural supports. These services MUST be individualized for each child and family to achieve outcomes as outlined in the Comprehensive Service Coordination Plan. The wraparound approach is best suited for children and families with complex mental health and related needs who have not benefited by traditional services.

# Utilization Management Roles and Responsibilities

## JBH Roles and Responsibilities

- Authorize ICTS /ITS/acute services for JBH children/adolescents
- Conduct on-going UM for children approved for services in ICTS or higher level of care.  
This includes:
  - ICTS
  - Day Treatment
  - Psychiatric Residential and/or Proctor Homes
  - Crisis and Hospital Alternatives
  - Acute Inpatient
- Conduct case reviews as appropriate
- Assist county CMHP's with UM for intensive outpatient services as requested
- Provide consultation and support to community care coordinators and service providers.
- Assist, as requested, child/family team in decision making for service planning
- Assist in resource identification and placement decisions through consultation and technical assistance to providers and local care coordinators.
- Identify training and educational needs for service providers to enhance service provision for children and families.
- Support the development and monitoring of a data management system that is capable of tracking children through multiple providers.
- Monitor implementation of guidelines and standards that enhance and promote quality, community based, child and family focused service delivery.
- Track MHO eligibility for continuity of services, specifically in ITS and acute levels of care.
- Track quality indicators and work with Child Serving Agencies to determine and develop plans as appropriate.

## Community Mental Health Program (CMHP) Roles and Responsibilities

Community Mental Health providers may contract with certified providers to assist with any of the responsibilities listed below. Should the CMHP's use such providers, each child/adolescent authorization should note the coordinating entity.

- Authorize outpatient and intensive outpatient mental health services and communicate with JBH Children's UM staff regarding treatment.
- Conduct UM for outpatient and intensive outpatient services.
- Coordinate treatment with JBH Children's UM staff

- Provide Care Coordination to children, especially those receiving intensive outpatient or higher services, or ensure the provision of care coordination through a designated provider.
- Screen referrals and recommend to JBH Children’s UM staff ICTS or higher level of care
- Meets with family to develop relationships and to identify strengths, needs, and treatment goals.
- Jointly coordinate and convene the Child and Family Team meetings with the family on an as needed basis.
- Coordinate with DHS/Child Welfare as appropriate
- Maintain case files and disseminate the Comprehensive Service Coordination Plan
- Maintain regular contact with the child, family, service providers, and representatives of other systems in which the child is involved.
- Provide or ensure appropriate case management services to include: assessing needs, identifying and coordinating services, monitoring services effectiveness, consultation, advocacy, crisis response, etc.
- Collaborate with the Child and Family team to adjust level or care to meet needs.
- Ensure the implementation of a transition plan to/from services and maintain involvement during transitions.
- Ensure the establishment of a Community Care Coordination Committee.

### **Child and Family Team**

The child and family team should be convened for each child who qualifies for ITCS and/or ITS level services. This team is facilitated by the County Child Coordinator or designee. Each team will be child specific, with members of the team selected by the child and family. Members should include:

- Child and Family
- Mental Health Service Provider(s)
- Child Welfare, Juvenile Justice, or OYA if applicable
- School representative if applicable
- Other community members, including friends, peers, clergy.
- County Child Care Coordinator, as facilitator, and can be a member of the team.

The Child and Family team is to meet on a regular basis, but at least quarterly. For services requested by the child/family and not deemed medically appropriate, JBH Child UM Staff will work with the child and family to ensure an appropriate alternative. Should the child/family object to any other level of care, JBH and/or County staff will follow the JBH policy on Denial of Services.

***General Treatment Guidelines***

JBH recognizes that services for children and families should not begin at the intensive service array. Prevention and lower level services are the preferred treatment options. There are instances when children only access the system in crises, and JBH and providers need to ensure the most appropriate services during this period of urgency. All services should be medically necessary and clinically required. Children should receive no more or no less than what is required. Essential treatment should be clinically appropriate, complete and timely

Treatment may be adequate but not essential if a more restrictive and costly alternative is used than the patient clinically requires. Or the treatment may be essential but inadequate when lack of coordination and services prolong treatment goal recovery.

To be medically necessary, the treatment must address a mental disorder, not be intended solely for self-improvement, stress reactions, or mandated by juvenile justice or child welfare. The treatment must address a recognized current DSM diagnosis, qualified by all five axes with the exception of interventions not generally appropriate or for diagnoses NOT COVERED under the Oregon Health Plan.

Services must be provided at the appropriate level of care relative to the severity of the child's illness and the child's capacity to respond to the treatment. In addition, services need to be delivered by a provider capable of rendering effective treatment for the child's clinical condition. When services are provided at the appropriate level, they are the most cost effective level of care that can safely be provided for that child's diagnosed condition.

***Treatment Guidelines for Levels of Care or Intensity of Services:***

JBH has established the following treatment guidelines for the accepted levels of care. The treatment guidelines describe the level of need matched to the intensity of services for each level of care. Levels of care are differentiated by the Intensity of Service provided at each level. Generally the higher the level of need, the more intense the service requirement. Each Level of Care attempts to match the level of need with the appropriate intensity of service. Levels of care become more restrictive and less normative as they increase. The levels of care are not intended to be of a specific duration or frequency. JBH recognizes that children have needs that may require varying the level of care based on changes in medical necessity. The guidelines are meant to describe the most commonly occurring needs of the children within a level of care and are not intended to be exclusive or all inclusive.

## **Outpatient Level of Care**

Description: Mental health services provided to children and adolescents who have a covered mental health diagnosis in a least restrictive and most normative setting.

Characteristics: Most commonly children in this level of care have limited social supports and impaired interpersonal functioning due to their mental illness. The child's natural support system is experiencing challenges, e.g. multiple stressors in the home, family or caregivers lack resources or have difficulties in accessing entitlements, available community resources; and language and/or cultural factors may pose barriers to accessing services.

Intensity of Services based on needs: These children require brief intervention or short term crisis intervention and stabilization consisting of:

- Assessment and Evaluation of a mental health condition.
- Brief focused therapy – individual, family, or group generally of less than 6 months duration.
- Strengthening ties within the community
- Identifying and building on innate strengths of the family and/or other natural supports
- Preventing the need for long term treatment.
- Crisis Services and immediate triage and referral to urgent and emergent mental health services.

Outpatient care is Subcapitated to the 6 county CMHP's within the JBH region. Each CMHP is responsible for managing and paying for treatment for children receiving this level of care.

## **Intensive outpatient treatment services Level of Care**

Description: Intensive outpatient services are outpatient services that have a higher intensity level than outpatient services, and should be delivered for a duration that is child and family specific, no more or no less.

Characteristics: Children in this level and intensity of service most commonly have a level of need determination using a CASII of III or above; however, treatment within the intensive outpatient level of care is the most normative and appropriate for the child and/or family; and is adequate to prevent the mental health condition from becoming more disabling, interfere with functioning at school and home, and prevent the child from requiring a higher level of care which is more intensive and less normative.

Intensity of Services based on Need: Most commonly children in this level of care require services that are more frequent and of longer duration than Outpatient level of Care. Children in this level of care may require all of the services available in outpatient level of care in addition to the following:

- Coordination of services with other agencies that are involved in the child and families formal and informal support network.
- Intensive case management and assistance with obtaining benefits and eligibility for other programs the child may be entitled to due to disability or unmet social needs.

These services are Subcapitated to the 6 county CMHP's within the JBH region. Each CMHP is responsible for managing and paying for treatment for children receiving this intensity of services. As this intensity of services indicates children and families at a higher need level, CMHP's will notify JBH Child UM staff of child placement within this level of care. JBH will provide Care Coordination funding for children and families in intensive outpatient treatment.

### **Intensive Community-Based Treatment and Support (ICTS) Level of Care**

Description: Intensive children's community-based treatment and support services are high intensity treatment of a duration that is child and family specific.

Characteristics: Children who most often receive ICTS services are children who are exhibiting disruptions in one or more areas of functioning and are assessed by the Community Mental Health Program as having intensive mental health needs. Included in this level of care are children who have received outpatient or intensive outpatient services and were unable to improve or be maintained at the lower level of care. Also included in this level are children who have previously received treatment at a higher level of care but have transitioned to ICTS level of care to maintain their recovery or gains made at the higher level of care. Also included in this level of care are children who enter the mental health system with a high level of acuity through the community based crisis system or the acute care system for children and adults. Children who are served in this level of care may require all of the services available in outpatient level of care and intensive outpatient level of care as well as services listed below.

- Care Coordination to coordinate multiple agency involvement.
- Care Coordination to coordinate multiple provider involvement.
- Care Coordination to coordinate mental health services in out of home placements
- Care Coordination and Intensive services using wrap around approach to prevent out of home placement
- Intensive services to reduce or prevent admission to acute inpatient psychiatric facility or other intensive treatment program
- Intensive services using wrap around approach to prevent and/or reduce care giver stress.
- Intensive services using wrap around approach to prevent and/or reduce school disruption due to escalating or emerging mental health symptoms.
- Intensive services using wrap around approach to prevent and/or reduce imminent risk of harm to self or others.

Intensity of Services based on need: The level of need required for Intensive Community based Treatment and Support must meet the requirements of the Oregon Administrative Rules.\

Intensive Community Based Treatment and Support is funded directly by JBH on a contractual basis with providers of direct services, including county CMHPs.

### **Intensive Treatment Services**

Description: Intensive Treatment Services are intensive mental health services for children provided by State certified providers in accordance with the requirements of Oregon Administrative Rules. Intensive Treatment Services represent the most intensive and restrictive level in the Children's system of care. Intensive Treatment Services are generally facility based and are not available to children with mild to moderate mental health needs making them the least normative services in the children's system of care.

Characteristics: Children in Intensive Treatment Services are unable to be treated at one of the lower levels of care due to a higher level of need. Physicians Certificate of Need is required for all children in Psychiatric Residential Treatment Service level of care.

Most commonly children served in the Intensive Treatment Service Level of care meet the following guidelines:

1. **Day Treatment Services** - Children who most often require this service typically exhibit the following characteristics:
  - CASII IV and above.
  - Child not able to be maintained with intensive outpatient or ICTS services
  - Child does not require more intensive services with 24 hour care and/or observation.
  - Mental Health disorder is a substantial barrier to home, school or community functioning..
  
2. **Psychiatric Residential Treatment Services, including Proctor Homes** - Children who most often receive this service typically exhibit the following characteristics:
  - Child has a CASII at level V or VI. CASII Level IV is at times appropriate if a lower level of care is contraindicated based on Psychiatric Recommendation.
  - Child requires 24 hour treatment and observation in a structured environment under the direction of a psychiatrist.
  - Child is not able to be maintained through ICTS or day treatment services, including in-home wraparound services as a result of a recent assessment (within 60 days) of the severity of the child's mental health disorder.

Intensity of Services based on need: The level of need required for Intensive Treatment Services must meet the requirements of the Oregon Administrative Rules.

### **3. Acute Inpatient Hospitalization or Subacute Alternative to Hospitalization**

Children placed at this level of care require intensive monitoring and multidisciplinary interventions available on a 24 hour, 7 day a week availability. The Acute Inpatient level of care is monitored and authorized under the Adult and Child Acute Care Utilization Management Plan.

#### **Level of Need (LON) Determination**

All children referred for ICTS and/or ITS level services must have a LON determination done prior to request for authorization of services. The CMHP may elect to do a LON determination on all children that present for service as part of their initial Intake and Comprehensive Mental Health Assessment.

The LON determination will be based on the following four factors:

- Comprehensive Mental Health Assessment
- CASII Score
- The number of other risk factors influencing the child's mental health diagnosis
- Input from family members and natural supports, juvenile justice, child welfare, and educational professionals working with the child and family.

The LON must be clearly communicated to the child and family, and the legal guardian must sign consent for this determination (Refer to Attachment 1)

#### **Service Authorization**

ICTS and/or ITS services should be requested by CMHP Child Care Coordinators through submission of either of these two forms:

- Authorization Request for ITS Services
- Authorization Request for ICTS Services

Each request should be submitted with any required documentation that supports the request for the specific services requested.

Completed Authorizations shall be reviewed within three (3) business days, and notification of the County Child Care Coordinator shall be done. Within this timeframe, the JBH Child UM staff may request other supporting clinical documentation for level/intensity of care determination and authorization.

Incomplete authorizations forms shall be returned to the County Care Coordinator for completion.

# Intensive Community Based Treatment Services Levels of Care

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

1. The child is a JBH member eligible under the rules of the Oregon Health Plan.
2. There is a Level of Need Determination using the CASII that documents the need and eligibility for the intensive service array at the ICTS level of care or higher.
3. There is a recent mental health assessment documenting the presence of a mental health diagnosis that is an approved diagnosis on the current Health Services Commission list of covered diagnoses.
4. The assessment includes a list of functional impairments (problems) that are the result of the covered mental health diagnosis that are the subject or focus of treatment at the ICTS level of care.
5. Services to be provided at the ICTS level of care are not available or would not be effective at the outpatient or intensive outpatient level of care.

**Continued Stay Criteria (must meet all of the following)**

1. The child continues to meet the criteria for admission to ICTS level of care.
2. The child continues to show progress in meeting one or more of the treatment Goals and/or objectives, or there is a change in the goals and /or objectives where progress can be reasonably expected over time.
3. The goals and/or objectives of the Service Coordination Plan remain achievable and can be reasonably expected to improve, stabilize, and/or prevent deterioration of the child's level of functioning.
4. Active treatment is occurring including frequent assessment, review, and coordination of care.
5. A transition plan has been developed with measurable objectives that describe the level of functioning required for discharge. The transition plan also describes the level of support that will be required to maintain functioning after transition. There is documented progress made in preparing the child and preparing the appropriate home environment since the last utilization review (90 days).

**Transition Criteria (must meet one of the following)**

1. Transition to a lower level of care occurs when the child and the home environment have met the goals and/or objectives in the transition plan. This could include a

remission of the symptoms of the mental illness, improvement in the child's functioning level, and/or improvement in the level of support in the home environment.

2. Transition to a lower level of care may occur at any time at the request of the parent or legal guardian.
3. Transition to a lower level of care may occur at any time with the agreement of the child and family team and in the presence of an adequate and appropriate treatment plan at the lower level of care.
4. Transition to a higher level of care may occur when the ICTS level of care is unable to achieve the goals and/or objectives necessary to maintain the safety and health of the child.
5. Transition to a higher level of care may occur when there is no progress at the ICTS level of care and the child's level of functioning is deteriorating to the point that a higher level of care is medically necessary.

### **Medically appropriate timeframes**

JBH and the CMHP's have a joint responsibility to ensure that upon admission:

1. There is a Service Coordination Plan that includes a list of goals and/or objectives to address the functional impairments described in the assessment that can be addressed at the ICTS level of care.
2. The goals and/or objectives of the Service Coordination Plan are achievable and can be reasonably expected to improve the child's level of functioning.
3. The Service Coordination Plan describes the most efficient and effective method to deliver the needed services.
4. A Child and Family Team is identified and organized jointly with the family that is timely to meet the child and families needs. Urgent and/or emergent services and intensive outpatient services are available as needed until a child and family team is convened.
5. A Child and Family Team meeting is convened and an initial Comprehensive Service Coordination Plan, including any necessary crisis prevention and intervention planning, is developed within 14 days from the date the provider receives a request for ICTS services.
6. The Comprehensive Services Coordination Plan is completed within 30 calendar days from the date a provider receives an authorized request for ICTS services.
7. The Comprehensive Service Coordination Plan is reviewed and modified whenever there is a change in the level of care.

## **Authorizations**

Authorizations for ICTS level of service will be up to 90 days in length. Services can be reauthorized if the child meets the continued stay criteria for this level of care.

Reauthorizations must:

- Be submitted 10 working days prior to current authorization expiration.
- Provide supporting data which clearly documents the continued need for this level of care. (Refer to Attachment 2)
- Reauthorization shall be reviewed within 5 working days, a determination made, and the Child and Family Team and the Provider shall be notified prior to the expiration of the current authorization.
- JBH Child UM staff may request further data, either written or oral, as needed to make a determination.

**Admission Requirements (must meet all, 1-9)**

1. The child is a JBH member eligible under the rules of the Oregon Health Plan.
2. There is a Level of Need Determination using the CASII that documents the need and eligibility for the intensive service array.
3. There is a recent mental health assessment documenting the presence of a mental health diagnosis that is an approved diagnosis on the current Health Services Commission list of covered diagnoses and the diagnosis is paired with the Day Treatment Service Code.
4. The assessment includes a list of functional impairments (problems) that are the result of the covered mental health diagnosis that are the subject or focus of treatment at the Day Treatment level of care.
5. There is a Service Coordination Plan that includes a list of goals and/or objectives to address the functional impairments described in the assessment that can be addressed at the Day Treatment level of care.
6. The goals and/or objectives of the Service Coordination Plan are achievable and can be reasonably expected to improve the child's level of functioning.
7. Based upon an assessment of the following risk factors the Child and Family team has determined that a lower level of care would not be adequate to protect the child and/or prevent further disruption to school, home, or community functioning.
  - a. Increasing or significant risk of harm to self or others
  - b. Frequent/imminent admission to acute inpatient psychiatric hospital or other intensive treatment services
  - c. Significant risk of an out of home placement due to mental health symptomatology
  - d. Caregiver stress due to child's mental health symptomatology
  - e. School disruption due to mental health symptomatology
  - f. Multiple agency involvement.
8. Child requires the intensive focus of Day Treatment and a multidisciplinary approach to treatment and education in order to benefit from treatment. This criteria can be established in one of the following ways:
  - a. Documented failure at a lower level of treatment
  - b. Documentation of an increase in symptoms and/or deterioration of functioning over a 90 day period of time while being treated at a lower level of care.

- c. Documentation of an increase in symptoms and/or deterioration of function over a short (less than 90 day) period of time in the absence of an effective mental health treatment.
  - d. Documentation of an emerging co-occurring behavioral health disorder with an associated increase in symptomatology and decline in functioning that requires a high level of treatment structure and support
9. Day Treatment services can reasonably be expected to meet the child's needs so that the treatment will be adequate and successful.

**Continued Stay Criteria (must meet all of the following)**

1. The child continues to meet the criteria for admission to Day Treatment level of care.
2. The child continues to show progress in meeting one or more of the treatment Goals and/or objectives.
3. The goals and/or objectives of the Service Coordination Plan remain achievable and can be reasonably expected to improve, stabilize, and/or prevent deterioration of the child's level of functioning.
4. Active treatment is occurring including frequent assessment, review, and coordination of care.
5. A transition plan has been developed with measurable objectives that describe the level of functioning required for discharge. The transition plan also describes the level of support that will be required to maintain functioning after transition. There is documented progress made in preparing the child and preparing the appropriate home and/or school environment since the last utilization review (90 days).

**Transition Criteria (must meet one of the following)**

1. Transition to a lower level of care occurs when the child and the home environment have met the goals and/or objectives in the transition plan. This could include a remission of the symptoms of the mental illness, improvement in the child's functioning level, and/or improvement in the level of support in the home and/or school environment.
2. Transition to a lower level of care may occur at any time at the request of the parent or legal guardian.
3. Transition to a lower level of care may occur at any time with the agreement of the child and family team and in the presence of an adequate and appropriate treatment plan at the lower level of care.

4. Transition to a higher level of care may occur when the Day Treatment level of care is unable to achieve the goals and/or objectives necessary to maintain the safety and health of the child.
5. Transition to a higher level of care may occur when there is no progress at the Day Treatment level of care and the child's level of functioning is deteriorating to the point that a higher level of care is medically necessary.

# Psychiatric Residential Treatment

## VII Levels of Care, Including Proctor Homes

### Admission Requirements (must meet all, 1-10)

1. The child is a JBH member eligible under the rules of the Oregon Health Plan.
2. There is a Level of Need Determination using the CASII that documents the need and eligibility for the intensive service array.
3. There is a recent mental health assessment and a psychiatric assessment within 60 days, recommending psychiatric residential treatment as the medically necessary and appropriate level of care. The psychiatric assessment documents the presence of a mental health diagnosis that is above the line on the current Health Services Commission list of covered diagnoses and the diagnosis is paired with the Psychiatric Residential Treatment Service Code.
4. The assessment includes a list of functional impairments (problems) that are the result of the covered mental health diagnosis that are the subject or focus of treatment at the Psychiatric Residential Treatment level of care.
5. A certificate of necessity (CON) is completed by a JBH consulting psychiatrist who agrees with the recommendation for Psychiatric Residential Treatment level of care based on the information available for review.
6. There is a Service Coordination Plan that includes a list of goals and/or objectives to address the functional impairments described in the assessment that can be addressed at the Psychiatric Residential Treatment level of care.
7. The goals and/or objectives of the Service Coordination Plan are achievable and can be reasonably expected to improve the child's level of functioning.
8. Based upon an assessment of the following risk factors the Child and Family team has determined that a lower level of care would not be adequate to protect the child and/or prevent further disruption to school, home, or community functioning.
  - a. Increasing or significant risk of harm to self or others
  - b. Frequent/imminent admission to acute inpatient psychiatric hospital or other intensive treatment services
  - c. Significant risk of an out of home placement due to mental health symptomatology
  - d. Caregiver stress due to child's mental health symptomatology
  - e. School disruption due to mental health symptomatology

- f. Multiple agency involvement.
9. Child requires the intensive focus of Psychiatric Residential Treatment and a multidisciplinary approach to treatment in order to benefit from treatment. This criteria can be established in one of the following ways:
  - a. Documented failure at a lower level of treatment
  - b. Documentation of an increase in symptoms and/or deterioration of functioning over a 90 day period of time while being treated at a lower level of care.
  - c. Documentation of an increase in symptoms and/or deterioration of function over a short (less than 90 day) period of time in the absence of an effective mental health treatment.
  - d. Documentation of an emerging co-occurring behavioral health disorder with an associated increase in symptomatology and decline in functioning that requires a high level of treatment structure and support
10. Psychiatric Residential Treatment services can reasonably be expected to meet the child's needs so that the treatment will be adequate and successful.

**Continued Stay Criteria (must meet all of the following)**

1. The child continues to meet the criteria for admission to Psychiatric Residential Treatment level of care.
2. The child continues to show progress in meeting one or more of the treatment Goals and/or objectives.
3. The goals and/or objectives of the Service Coordination Plan remain achievable and can be reasonably expected to improve, stabilize, and/or prevent deterioration of the child's level of functioning.
4. Active treatment is occurring including frequent assessment, review, and coordination of care.
5. A transition plan has been developed with measurable objectives that describe the level of functioning required for discharge. The transition plan also describes the level of support that will be required to maintain functioning after transition. There is documented progress made in preparing the child and preparing the appropriate home and/or school environment since the last utilization review (30 days).

**Transition Criteria (must meet one of the following)**

1. Transition to a lower level of care occurs when the child and the home environment have met the goals and/or objectives in the transition plan. This could include a remission of the symptoms of the mental illness, improvement in the child's functioning level, and/or improvement in the level of support in the home and/or school environment.

2. Transition to a lower level of care may occur at any time at the request of the parent or legal guardian.
3. Transition to a lower level of care may occur at any time with the agreement of the child and family team and in the presence of an adequate and appropriate treatment plan at the lower level of care.
4. Transition to a higher level of care may occur when the Psychiatric Residential Treatment level of care is unable to achieve the goals and/or objectives necessary to maintain the safety and health of the child.
5. Transition to a higher level of care may occur when there is no progress at the Psychiatric Residential Treatment level of care and the child's level of functioning is deteriorating to the point that a higher level of care is medically necessary.

**Certificate Of Need Team Process**

1. The JBH Child UM staff will forward the clinical documentation to a designated psychiatrist who meets the following criteria:
  - Is not involved in the care or treatment of the individual being referred for psychiatric residential care.
  - Is competent in the areas of diagnosis and treatment of child psychiatric disorders.
  - Becomes knowledgeable about the child's situation through a comprehensive review of clinical records and other data provided by the CON Team.
2. The JBH Child UM staff will be responsible for convening the CON Team twice weekly through a regularly scheduled (TBA) Telephone Conference (refer to Attachment 3)
3. The CON Team will place on the agenda a specific Child request within 3 days of receipt of the required documentation.

The CON Team may consist of the following:

- Psychiatrist (as defined above)
- County Care Coordinator
- JBH Children's UM Staff
- Child Welfare representative if the child is involved with this agency
- Any other person deemed appropriate by the JBH Child UM Staff

**Approval of Certificate Of Need**

If the individual is approved for certification by the CON Team, County Care Coordinator will inform the client and family within 3 working days and pursue placement and request an appropriate authorization.

The Child and Family Team will assure appropriate safety plans and services are in place, pending availability of placement. The client's Comprehensive Service Coordination Plan will be appropriately reviewed and revised.

**Denial of Psychiatric Residential Service**

If the criteria for certification have not been met, JBH shall issue a denial of services letter for this level of care clearly stating the rationale for not authorizing care at this level, and providing information to the family on their appeal rights (refer to the JBH Policy and Procedure on Grievances, Appeals, and Hearings). In addition, County Care Coordinator shall speak with the child, family, and Child and Family Team members within three days of the CON process to

review the treatment options and reasons for denial of this level of care. County Care Coordinator and JBH Child UM staff shall work with the Child and Family team to develop a revised Service Coordination plan that can help stabilize and adequately meet the needs of the individual and family.

### **Urgent/Emergent Residential Service Provisions**

It is recognized that crises and emergencies arise, necessitating flexibility in the referral and certification of need process. It is also recognized that a few children may come to the attention of mental health service providers during an acute mental health crisis, exhibiting emergent, urgent psychiatric medical needs, without a prior history of receiving mental health services and with no completed prior mental health assessments. In these instances it is a requirement that the provider complete a comprehensive mental health assessment within 14 days from the date of admission to a psychiatric residential facility. This comprehensive mental health assessment shall include planning and arranging for immediate aftercare placements in a less restrictive setting. On completion of this assessment, the CON's Team shall meet to review whether the child meets criteria for this level of care. Prior to the final authorization from the CON's team, JBH will issue a conditional authorization of 14 days duration.

### **Authorization for Non Urgent/Emergent Residential Services**

If the child is approved for this level of care, the initial authorization period will be 30 days. Continued stay reviews are conducted every 30 days.

### **Voluntary Absences**

Voluntary absences in which the treatment team, including the child and parent/guardian, plan home environment transitions of a short duration, must be included in the Comprehensive Service Coordination Plan and clearly articulated to JBH prior to any absence. It is also an expectation that any child on a leave from a residential facility must receive on-going supports and treatments when NOT in residence at the facility. For leaves of 5 days or less within one month and with continued supports while at home, the child will be maintained within the residential case rate. Documentation in the clinical record must clearly show days at home, supports given, and outcomes of home visits. If voluntary visits extend beyond 5 days per month, the child will be transitioned to Residential transitional funding.

### **Involuntary Absences**

Involuntary absences are any absence not planned or anticipated within the Comprehensive Service Coordination Plan. Residential level of care will be terminated if the involuntary absence exceeds 24 hours or if the child/adolescent is incarcerated. JBH UM staff, in consultation with the residential facility will determine further treatment options for the child and family.

## ***Comprehensive Community Based Assessment and Evaluation (CCBAE)***

Evaluating the child in the context of his or her family, school, community, and culture is central to all assessments. It is the policy of JBH that children receive the most benefit from assessments and evaluations in a normative setting; therefore, the preferred multifaceted, multiday assessment should take place in the home, school, and/or community environment to best evaluate the mental health of the child.

### **Criteria for Community Based Assessment and Evaluation (CCBAE)**

1. There is a Level of Need Determination using the CASII that documents the need and eligibility for the intensive service array at the Psychiatric Residential Treatment level of care or higher.
2. Based upon an assessment of the following risk factors the Child and Family team has determined that a Community Based Assessment and Evaluation is necessary to prevent further disruption to school, home, or community functioning.
  - a. Increasing or significant risk of harm to self or others
  - b. Frequent/imminent admission to acute inpatient psychiatric hospital or other intensive treatment services
  - c. Significant risk of an out of home placement due to mental health symptomatology
  - d. Caregiver stress due to child's mental health symptomatology
  - e. School disruption due to mental health symptomatology
  - f. Multiple agency involvement.
3. The Child and Family Team has considered the risks and benefits and there is substantial agreement among team members that the benefits to the child and family of a Community Based Assessment outweigh the benefits of a facility based assessment and evaluation and the risks would not be significantly higher than in a residential based assessment and evaluation.
4. The family or guardian gives voluntary and informed consent to a Community Based Assessment and Evaluation
5. There is a reasonable clinical expectation that the child and family will benefit from a Community Based Assessment and Evaluation based in part on the willingness and ability of the parents or caregivers to participate in the evaluation and assessment

6. There is an adequate working relationship between agencies and providers assisting the child and family to ensure the success of a Community Based Assessment and Evaluation

### **Minimum Requirements of the Community Based Assessment and Evaluation**

1. The assessment must take place primarily within community settings (i.e. home, school, respite, boys and girls club, athletic events, etc.) and at times, places, and of durations that are convenient for the family
2. A “Family Navigator” or other advocate shall be available to assist the child and family with the process
3. The assessment must be multidisciplinary involving physicians, social workers, mentors, educators, and other professionals selected to assist with the child’s individual needs
4. The multidisciplinary assessment team must assess the child and family strengths including cultural strengths and preferences, and include the role of the strengths in addressing deficits and needs and preserving the family unit

JBH supports the use of various service modalities that best suit the individualized, child and family centered treatment in the most normative, least restrictive setting. Providers will find a full list of codes for their use in the JBH Provider manual. Attachment 4 lists some of the most commonly used codes for ICTS level of services. When using a code that is not on the list the provider must check with JBH to determine if the code is approved for the services being proposed. The Health Services Commission has prioritized diagnoses for coverage that are linked with treatment pairs. Not all treatment codes are approved for all diagnoses. Providers are responsible for ensuring that the treatment code is approved for the diagnosis.

Providers need to make sure when using service codes for billing that the following occur:

1. The service is clearly documented in the clinical record as specified by Oregon Administrative Rules. Documentation needs to:
  - a. State service type provided
  - b. Length of treatment service provided, e.g. 30 min, 1 hour.
  - c. Document that service covered goals/outcomes as specified in the Comprehensive Service Coordination Plan
  - d. Clearly document outcomes achieved by the service, problems and issues identified, and changes to the Comprehensive Service Coordination Plan anticipated.
  - e. Be signed by the person delivering the service with their name and credentials.
2. The billing code used clearly identifies the professional qualifications of the person delivering the service by using the appropriate modifiers.
3. The length of time billed is reflective of the clinical note.  
The service delivered matches the definitions of the service codes listed in the JBH Provider Manual.

**JBH Service Packages:**

The individual service packages are designed to achieve the most effective care for children/families in the least restrictive environment. JBH can not guarantee providers specific numbers of children within any case rate package as services are designed to best serve the mental health needs of the children/adolescents and their families.

**Service Packages:**

The services packages listed below show the total rate in monthly increments. Authorizations may be made in one month, two month and three month increments. The monthly rate will be used to calculate the total available amount to cover the entire authorization or reauthorization. In ICTS where the monthly amount is a cap rather than a case rate, the total authorization will be the cap and may be spent at anytime during the authorized period. Caserates are for a one month period of time except as described in "Payment of Case Rates for less than a Full Month" as described below.

**CMHP Care Coordination and Service Planning Responsibility:**

All Care coordination, screening for service determination, and Service Plan implementation and revisions are the responsibility of the CMHP to which the child is assigned. CMHP may delegate the responsibility to any certified provider to provide Care Coordination. However, the CMHP must retain the responsibility for Resource Management. The Care Coordinator shall work with each child and family and coordinate with each service provider to ensure the most appropriate service is being delivered to meet the treatment goals and outcomes.

CMHP's or designee will be compensated at a rate of \$125 per month per child authorized for intensive outpatient, ICTS, day treatment, and residential treatment. In Counties where the Care Coordination is delegated it will be up to the CMHP to determine how much of the rate is provided for Care Coordination and how much is to be spent on Resource Management. This is to ensure continuing Care Coordination and planning and improve outcomes for children and families.

## Case Rate Service Packages

### ***ICTS Service Packages:***

ICTS service packages are not at case rates but are at Fee-For-Service upper limits. Services can be any outpatient code listed in either Attachment 3 in Section XII or the full listing of codes found in the JBH Providers Manual. **ICTS services may not be used in conjunction with the Case Rate packages described below as the Case Rates include the provision of ICTS services.**

**Level 1 (moderate needs)** – Maximum of \$850 per month per authorized child at this level of care. Children at this level must have adequate documentation of need that meets the criteria described in the Children’s Utilization Management Plan. Services may be authorized at this level for up to 90 Days.

**Level 2 (High needs)** – Maximum of \$1,200 per month per authorized child at this level. Children at this level must have adequate documentation of need that meets the criteria described in the Children’s Utilization Management Plan. Services may be authorized at this level for up to 90 Days. When the authorization is due for reauthorization, reauthorization will be at the level that is adequate but does not exceed the level of billed services during the authorization period.

**Level 3 (Intensive Needs)** – Maximum of \$1,650 per month per authorized child at this level. Children at this level must have adequate documentation of need that meets the criteria described in the Children’s Utilization Management Plan. Services may be authorized at this level for up to 90 Days. When the authorization is due for reauthorization, reauthorization will be at the level that is adequate but does not exceed the level of billed services during the authorization period.

### ***Behavioral Rehabilitation Services (BRS) - \$350 per month, all inclusive case rate.***

Children in BRS facilities requiring outpatient level of care shall have this all inclusive case rate package. If a child requires more than this level of care as evidenced meeting the admission criteria, and a Comprehensive Service Coordination Plan states goals and objectives of a higher level of care, then that specific child shall be assigned to another level of care and payment option.

### ***Day Treatment – partial day package including ICTS service augmentation - \$1,820 per month, all inclusive case rate.***

The partial day package is for less than 4 hours per day of day treatment, including the provision of ICTS services. Services included within the day treatment rate are noted in applicable OAR. The all inclusive rate covers the authorized child on a 24/7 basis.

***Day Treatment - Full Day Package including ICTS service augmentation - \$3,456 per month, all inclusive case rate.***

The full day treatment package is inclusive of any and all services as specified by Oregon rules that an authorized child may require on a 24/7 basis during this level of care. The rate is inclusive of psychiatric medication management. ICTS services under this package must be services NOT covered under the day treatment OAR, and delivered in hours other than that of the day treatment program.

***Residential transitional package -\$5,860 per month per authorized child***

This includes a combination of very brief residential services interspersed with community based intensive services in a wrap-around model, delivered on a 24/7 bases throughout the authorization period.

***Residential Treatment Service, including Proctor Home, Package - \$9,100 per month per authorized child***

This is an all inclusive rate for all services delivered to each authorized child on a 24/7 basis.

***Comprehensive Community Based Assessment and Evaluation - \$900 per evaluation.***

A Comprehensive Community Based Assessment and Evaluation should be completed within a two-week period of time. This service is limited to once every two years. This service includes a multiday, multidimensional assessment and evaluation of the child and family in the home, school, or other social and/or community environments that will best assess the child's mental and behavioral issues.

***Inpatient Hospitalization or alternatives to inpatient services:***

Children admitted to an inpatient facility shall be under the guidelines of the JBH Utilization Management Plan and Protocols for inpatient admission, continued stay, and discharge.

**Provider Responsibility for Services under a Case Rate:**

- It is each provider's responsibility to ensure that a full service array is available for each child for which they are authorized to deliver services. Should the provider not have staff internally capable of delivering some of the services, the provider will need to contract and pay for any specific service required for the each child within the case rate provided. Providers receiving a case rate may request JBH UM staff to submit a subauthorization to PHTech that will allow payment for the authorized services to be charged against the case rate by contracted providers. If providers do not use PH Tech they will be responsible for encountering the services that they do not provide directly. No other funds will be expended during the month for authorized child assigned to a specific package.

- It is each provider’s responsibility to notify JBH of a discharge/termination from ICTS or ITS level service that occurs prior to an authorization expiration date. Notification should occur within 24 hours of termination, or the first business day after a weekend or holiday should the termination occur on a weekend or holiday.

**Payment of Case Rates for less than a full month:**

Case rates are paid on a monthly basis, retrospectively for all services delivered to the child during the previous month. The rate will be paid upon receipt of encounter/billing data to PH Tech. Each case rate payment will be paid to the principle authorized provider designated to deliver services to the child. Should a provider need other facilities and/or providers to treat a child, it is the responsibility of principle authorized provider to contract for and pay for any service covered under the case rate.

For children admitted into a program during a month, the case rate will be prorated as follows:

Prorated Case Rates for Mid Month Admissions and Discharges.	
Days per month in treatment	Prorated amount of case rate
24 or more	Full payment
17 to 23	3/4 payment of rate
8 to 16	1/2 payment of rate
7 or less days	1/4 payment of rate

## **Attachment 1 Parent/Guardian Consent for Intensive Service Array Screening and Services**

I understand that my child has been referred for an OHP benefit package called the Intensive Service Array. I also understand that a Level of Need Determination (LON) will be done, including a Child Adolescent Service Intensity Instrument (CASII) to determine if my child meets the criteria to receive services under the Intensive Service Array. The CASII screening involves reviewing available background documents, which may include my child's mental health, medical, and/or alcohol and drug records. The LON screening process may also require a review of records from DHS Child Welfare, Juvenile Justice, and/or the Oregon Youth Authority if these agencies are/or were involved with my child. I understand that information used for the LON screening and the results of that screening will be kept confidential unless I sign an Authorization to Disclose Information, or if disclosure is otherwise allowed by law. I understand that the LON screening is voluntary.

I understand that if my child is eligible for the ISA, a Care Coordinator will be assigned to my family. The Care Coordinator will assist my family in identifying goals and needs, and will help with obtaining mental health service for my child.

I hereby give consent for my child to participate in the LON screening. And if my child meets the eligibility criteria for the Intensive Service Array, I further consent for a Care Coordinator to provide or arrange for all services and activities for my child. I can withdraw my consent at anytime, and if I do, any activities or services already received cannot be revoked.

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Signature

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Date

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Witness Signature

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Date

**Attachment 2 Information and Input Needed from Child and Family Team Prior to CON Determination**

Where Info Comes From	Information Requested
Data Base	When was the child determined to be ICTS eligible?
Data Base	Who is on the Child and Family team?
Telephone Conf	How often does the Team meet? Date of last meeting
Telephone Conf	Information from Service Coordination Plan: a. What are the strengths of the client and family? How have they been utilized to date in helping the child and family do better? b. What needs have been identified and actions recommended related to services or supports? c. Of these, what has been tried? What worked, what didn't work? What were the barriers to success? What were the complicating factors?
Telephone Conf	Psychiatric Profile: What are the diagnostic issues? What medications have been tried? What are the recommendations?
Telephone Conf	What is happening today that makes you think this client requires Psychiatric Residential Treatment or Residentially Based Assessment and Evaluation?
Telephone Conf	Would this intensive psychiatric need still be present if the child had a stable place to live with all the recommended, intensive community based services available and accessible?
Telephone Conf.	What are the goals for the service you are asking? What function would this service be providing that could not be accomplished in the community? What specific outcomes are you hoping for? If asking for assessment, what specific assessment questions you would like to see answered? What will be the indication that the child is ready to transition to a community based setting? What is the estimate of how much time this will take, from the time of admission?

### Attachment 3 Codes for Use in Outpatient, Intensive Outpatient, and/or ICTS

Codes	Description	Definition for Use
H004	Individual counseling or therapy per 15 minutes by a QMHP other than a Psychiatrist, Child Psychiatrist, Psychologist, or PMHNP.	Individual counseling or therapy in the planned treatment of a child's problem(s) as identified by an assessment and listed in the Service Plan. The intended outcome is the management, reduction or resolution of identified problems
90862	Medication management by a physician or PMHNP	Medication management by an MD or Mental Health Nurse Practitioner
90882	Environmental intervention with agencies or institutions – QMHP only	Interaction on behalf of the child and/or family with agencies involved with the child/family
T1023	Screening to determine the appropriateness of consideration of the child in a specified program, project or treatment protocol, per encounter – Use limited to Care Coordinator.	Screening or evaluation of the mental health service needs of clients for consideration of admission to inpatient acute care, crisis/respite, residential treatment or lower levels of care. This differs from a MH assessment in that the activity requires not only the evaluation of the child's treatment needs, but also an evaluation of available treatment options.
90853	Group Therapy	Therapy involving more than 3 participants in a planned treatment of a child's identified problems as listed on the Services Plan. The intended outcome is the management, reduction or resolution of identified problems
90846	Family Therapy without child present, 45 minutes or longer	Family counseling or therapy in the planned treatment of a child's problem(s) as identified by an assessment and listed in the Service Plan. The intended outcome is the management, reduction or resolution of identified problems.
90847	Family Therapy with child present, 45 minutes or longer	Same as above, but without child present.
H0031	MH Assessment, non physician	Determination of a child's need for MH services based on a collection and evaluation of data through interview and observation of a child's mental history and presenting problem(s). The assessment concludes with the documentation of a diagnosis and a

		written treatment plan supported by the assessment and interview data.
H032	Mental Health Service Plan Development by non-physician	Activities to develop, evaluate, or modify a child's mental health service plan. This would include the statement of treatment or service goals of clinical interventions designed to achieve those goals, and an evaluation of progress toward those goals. This activity may be repeated periodically and the plan may be modified.
G0176	Activity Therapy related to the care and treatment of a child's disabling mental health condition, 45 minutes or more	Therapeutic activities designed to improve social functioning, promote community integration and reduce symptoms in areas important to maintaining or reestablishing residency in the community, e.g., home, school, peer group. Activities are delivered to more than one child and are designed to promote skill development in areas such as stress management, conflict resolution, coping skills, problem solving, nutrition, parenting skills, etc.
H2032	Activity Therapy, per 15 min	Therapeutic activities in a structured setting designed to improve social functioning, promote community integration and reduce symptoms in areas important to maintaining or reestablishing residency in the community. Activities may be delivered on an individual or group basis and are designed to promote skill development and meet specific goals and measurable objectives in the treatment plan.
H2014 HO	Skills training and development, per 15 min. by QMHP	Services designed to reduce or resolve identified barriers and improve social functioning in areas important to establishing and maintaining the child in the community (home, school, peer group). Activities are delivered to more than one child and are designed to promote skill development in areas such as anger management, behavioral monitoring and reinforcement, social skills, life skills, etc.

H2014 HN	Skills training and development, per 15 min. by QMHA	Same as above, but delivered by a QMHA
S9125 HN, QMHA  S9125 HM, paraprofessional	Respite services in the home, per diem	Services provided in the home either to family or child, including such services as respite, aides, recreation, behavior monitoring, tutor or mentor, provided by an agencies staff under agency supervision. Agency supervision shall include training, supervision in adhering to the child's treatment plan and emergency back up support. Travel time is factored into the rate and may NOT be billed under a separate code.
H2011	Crisis intervention, QMHP	Unplanned face-to-face acute non-hospital intervention by a QMHP that is needed immediately in response to actual or perceived threat of harm to self or others, or risk of substantial and immediate deterioration of mental or emotional functioning.
H0045	Respite, not in home	Services provided in a properly licensed 24-hour facility by non-medical professionals within their scope of licensure or certification. Services must be reasonably expected to improve or maintain the condition and functional level and prevent relapse or hospitalization. Services include assessment, supervision, skills training and support, and case management.
H2021 HO	Community based wraparound by a QMHP per 15 min	Individualized, community-based clinical interventions, delivered as an alternative or addition to traditional services that are more likely to effectively treat a child's mental health condition. Services may include informal supports and resources and are provided to a child and family members in order to promote, maintain, or restore successful community living. Services are delivered as a result of a collaborative planning process and are provided in a manner or place different from the traditional manner or place of service delivery. Examples of services under this model included: school-based programs, mentoring programs, family education

		and support, crisis mobile outreach teams, culturally appropriate family support services, etc.
H2021 HN	Community based wraparound by a QMHA per 15 min	Same as above, but delivered by a QMHA
H2022	Community based wraparound per diem	Same as under H 2021, but for services greater than 4 hours per day, delivered by QMHA and/or QMHP's
T1005 HM	Family and child supports, less than bachelor's degree, paraprofessionals per 15 min	Services provided in the home or community to either the family or child including services such as respite, aides, recreation, behavioral monitoring, tutor or mentor, provided by agency staff under agency supervision. Agency supervision shall include training and supervision in adhering to the child's treatment plan and emergency back up support. Travel time is factored into the rate and may NOT be billed under a separate code.
T1005 HN	Family and child supports, QMHA per 15 min	Services provided in the home or community to either the family or child including services such as respite, aides, recreation, behavioral monitoring, tutor or mentor, provided by agency staff under agency supervision. Agency supervision shall include training and supervision in adhering to the child's treatment plan and emergency back up support. Travel time is factored into the rate and may NOT be billed under a separate code.
T1016 HO	Case management QMHP	Services provided for coordinating the access to and the provision of services from multiple agencies, establishing service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements and other services for the child and/or family.
T1016 HN	Case management QMHA	Services provided for coordinating the access to and the provision of services from multiple agencies, establishing service linkages, advocating for treatment needs, and providing assistance in obtaining entitlements and other services for the child and/or family.

T1016	Care Coordination QMHA, for CMHP use only	Ongoing communication and collaboration with children and families with multiple needs. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older children to the adult service system.
H2027	Psycho educational services, per 15 min	Activities to provide information and education to children, families, and others regarding mental disorders and their treatment. The activity acknowledges the importance of involving persons other than family that may be essential in assisting the child to maintain treatment and to recover.

Notes to codes:

H2012 is a more clinically oriented service code

T1005 should be used for mentoring for socialization skills or respite, e.g. taking the child on an outing while the family remains at home.

Modifiers as listed above MUST be used to denote professional level of service delivery.

## Attachment 4 Level of Service Guide

<b>Service Level</b>	<b>Who Requests and/or Helps Decide What Services are Needed?</b>	<b>Initial Authorization Period</b>	<b>Re-Authorization Period</b>	<b>Certificate of Need Required</b>	<b>Estimated Lengths of Care</b>	<b>Continued Stay Review Frequency</b>
Outpatient and Intensive Outpatient	Parent/Child and Outpatient Provider	Case open as long as the client is actively receiving services	Up to each County CMHP	No	Ongoing	Determined by each County CMHP.
ICTS	Child & Family Team	90 days	90 days	No	180 – 270 days	Every 90 days
Day Treatment	Child & Family Team	90 days	90 days	No	180 – 270 days	Every 90 days
Residential Proctor Home	Child & Family Team	30 days	30 days	Yes, prior to placement	90 – 180 days	Every 30 days
Residential Facility	Child & Family Team	30 days	30 days	Yes, prior to placement	60 – 120 days	Every 30 days
Crisis Respite & Stabilization	Community Mental Health Program	1-3 days	3 days	No	3 days	Not needed.
Acute Care	Community Mental Health Program	1-3 days	3-5 days	Approval by JBH UM staff	5-7 days	As determined by JBH UM Staff