



Minnesota Medicaid Supplemental Clinical Criteria: Prepaid Medical Assistance Program Minnesota Care Seniors Special Needs

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California (“Optum-CA”)). Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member’s specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member’s specific benefit, the member’s specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

Adult Mental Health Services

Mental health services should be directed at rehabilitation of the Member in the least restrictive clinically appropriate setting. Services include:

- Diagnostic assessment, psychological testing, and an explanation of findings to rule out mental illness or establish the appropriate mental health diagnosis in order to develop the individual treatment plan. All assessments must include the direct assessment of the member. Providers performing diagnostic assessments provide:
 - A screening for all adult members upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using a screening tool of the Providers’ choice, but must meet the following criteria:
 - Reading grade level of no more than 9th grade;
 - Easily administered and scored by a non-clinician;
 - Tested in a general population at the national level;
 - Demonstrated reliability and validity;
 - Documented sensitivity of at least seventy percent (70%) and overall accuracy of at least seventy percent (70%); and
 - Predicts a range of diagnosable major mental illnesses such as affective disorders, anxiety disorders, personality disorders, and psychoses, if a mental illness screening tool; predicts alcohol disorders and drug disorders, especially dependence, if a substance use screening tool; and both of the above, if a combined screening tool.
 - Preferred but not required criteria for screening tools include:
 - Short duration of screening process taking no more than ten (10) minutes or having ten (10) or fewer items per scale;
 - Widely used with adults; and
 - Tool can be used in either interview or self-report format.
- A screening for all adult members upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using the following nationally recognized screening tools on the IDDT web page: <https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/>

Adult Crisis Response Services

Adult Crisis Response Services are community-based services provided by a contracted crisis team to adults age 18 or older. Crisis assessment and intervention provided in an emergency department or urgent care setting (phone and walk-in) and Crisis assessment and intervention provided in the Member’s home or other agreed upon place in the community by mobile crisis response services

Admission Criteria

People with significant functional impairments as demonstrated by at least one (1) of the following conditions:

- The member is age 18 or older
- The member is experiencing a mental health crisis or emergency (i.e., A behavioral, emotional or psychiatric situation that would likely result in significantly reduced levels of functioning in primary activities of daily living or in the placement of the member in a more restrictive setting (such as inpatient hospitalization) or; A behavioral, emotional or psychiatric situation, which causes an immediate need for mental health services).
- The member has a co-occurring substance use disorder and do not need a detoxification facility

Crisis Assessment

A crisis assessment is an immediate, face-to-face evaluation by a physician, mental health professional or crisis-trained mental health practitioner, to:

- Identify any immediate need for emergency services
- Determine that the member's behavior is a serious deviation from his or her baseline level of functioning and caused by either a mental health crisis or emergency
- Provide immediate intervention to relieve the member's distress
- Evaluate, in a culturally appropriate way and as time permits, the member's current:
 - Life situation
 - Sources of stress
 - Symptoms
 - Risk behaviors
 - Mental health problems
 - Strengths and vulnerabilities
 - Cultural considerations
 - Support network
 - Level of functioning
 - Willingness to accept voluntary treatment
 - Whether the person has an advance directive
 - History and information obtained from family members
- Conduct the crisis assessment in one of the following locations:
 - The member's home
 - The home of a family member
 - Another community location
- Determine the need for crisis intervention services, or referrals to other resources, based on the assessment.

Crisis Intervention

Mobile crisis interventions are face-to-face, short-term, intensive mental health services provided during a mental health crisis or emergency. These services help the member to:

- Cope with immediate stressors and lessen his or her suffering
- Identify and use available resources and member's strengths
- Avoid unnecessary hospitalization and loss of independent living
- Develop action plans
- Begin to return to his or her baseline level of functioning

Mobile crisis intervention services must be:

- Available 24 hours per day, seven days per week, 365 days per year
- Provided by a mobile team in a community setting
- Provided promptly

Crisis Intervention Treatment Plan

With the member, develop, document and implement an initial crisis intervention treatment plan within 24 hours after the initial face-to-face intervention to reduce or eliminate the crisis. The treatment plan must be culturally and linguistically appropriate for the member.

- List the member's needs and problems identified in the crisis assessment
- Identify:
 - Frequency and type of services to be provided

- Measurable short-term goals
- Specify objectives directed toward the achievement of each goal
- Note cultural considerations
- Recommend needed services, including crisis stabilization
- Refer to appropriate local resources, such as:
 - County social services agency
 - Mental health services
 - Local law enforcement
- Write clear progress notes of the outcome of goals
- Identify frequency and type of services to be provided
- Coordinate the planning of other services with the member's case manager if they have one
- Update the crisis intervention treatment plan as needed to reflect changes in goals and services.

If the member shows positive change in a baseline of functioning or a decrease in personal distress:

- Make (and document) a referral to less-intensive mental health services
- Document short-term goals that have been met and when no further crisis intervention services are needed
- If the member is unable to follow-up with a referral, the crisis response provider must link the member to the service and follow-up to ensure that the member is receiving the service

A mental health professional and the member must approve and sign the treatment plan. If the member refuses to approve and sign the plan, note the refusal and the reason(s) for the refusal in the treatment plan. Give a copy of the treatment plan to the member.

If services continue 24 hours after the beginning of the face-to-face intervention:

- A mental health professional must contact the member face-to-face, on the second day, to provide services and update the crisis treatment plan
- The mental health professional is not required to be the same professional who was supervising the service when the face-to-face crisis intervention began

Crisis Stabilization

Crisis stabilization services are mental health services, provided after crisis intervention, to help the member return his or her functioning to the level it was before the crisis.

- Provide stabilization services:
 - In the community
 - Based on the crisis assessment and intervention treatment plan
 - Consider the need for further assessment and referrals
 - Update the crisis stabilization treatment plan
 - Provide supportive counseling
 - Conduct skills training
 - Collaborate with other service providers in the community
 - Provide education to the member's family and significant others regarding mental illness and how to support the member

Crisis Stabilization Treatment Plan

With the member, develop a crisis stabilization treatment plan within 24 hours of beginning services. The crisis stabilization treatment plan, at a minimum, must include:

- Problems identified in the assessment
- Measurable short-term goals and tasks to be achieved, including time frames for achievement
- Specific objectives directed toward achieving each goal
- Clear progress notes about outcomes of goals
- List of member's strengths and resources
- Documentation of participants involved
- A crisis response action plan if another crisis should occur
- Frequency and type of services initiated, including a list of providers, as applicable

A mental health professional and the member must approve and sign the treatment plan. If the member refuses to approve and sign the plan, note the refusal and the reason(s) for the refusal in the treatment plan. Give a copy of the plan to the member.

Adult Residential Crisis Response and Stabilization Services

Adult Residential Crisis Response - Adult crisis stabilization services are individualized mental health services provided following a crisis assessment and crisis intervention. The service is designed to restore the member to a pre-crisis level of functioning. Crisis stabilization services are provided in a residential setting for adults who need structure and assistance from 24-hour mental health staff and are at risk of hospitalization if they do not receive these services.

Admission Criteria

- The member is 18 years old or older
- The member has been assessed as experiencing a mental health crisis or emergency and interventions to help the member cope with immediate stressors have been initiated by a mental health crisis team, an emergency department or a mental health professional. (If a mental health practitioner completes this step, the clinical supervision must occur within three hours.)
- A mental health professional or mental health practitioner with clinical supervision determines that the member need's structure and support of residential crisis stabilization in order to restore his or her pre-crisis level of function. (If a mental health practitioner completes this step, the clinical supervision must occur within three hours.)
- Members may receive RCS instead of hospitalization, if appropriate.

Authorization Requirements

- Authorization is needed to exceed the maximum threshold of 10 days in a calendar month with the following supporting documentation:
- Crisis assessment
- Crisis stabilization treatment plan and progress notes
- Discharge plan or plans for transitioning to the community, including referrals to other service providers (services are coordinated after the member leaves the program)
- Symptoms that have not returned to the member's baseline level
- Other options considered, including hospitalization and community crisis stabilization
- Written explanation of why the member needs more time and the anticipated outcome

Service Delivery

- 24-hour on-site staff and assistance
- Assessment of the member's immediate needs and factors that lead to the crisis
- Individualized treatment to address immediate needs and restore member to pre-crisis level of functioning
- Supportive counseling
- Skills training as identified in the member's individual crisis stabilization plan
- Referrals to other service providers in the community as needed and to support the member's transition from RCS
- A crisis response action plan if a crisis should occur
- Assistance to access and store medication
- Room and Board

Adult Health and Behavior Assessment and Intervention

Health Behavior Assessment and Intervention is intended to identify psychological, behavioral, emotional, cognitive and relevant social factors that can prevent, treat, or manage physical health problems. Services must be associated with the patient's primary diagnosis, which is physical in nature, and focus on factors that could complicate the medical condition and treatment.

Health behavior assessments or reassessments require a referral from a physician or nonphysician practitioner. Documentation must show evidence of coordination of care with the patient's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment or intervention addresses.

Health and Behavior Assessment/Intervention under a physician's order to assess a member's psychological status in relation to a medical diagnosis, or in determining treatment. If further evaluation is required to determine a mental illness or emotional disturbance, a mental health diagnostic assessment is required.

Admission Criteria

- The member is hospitalized in a medical bed
- The member is receiving ongoing medical services in an outpatient setting

Covered Services

These services are for member's who have a primary physical diagnosis who may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient's health status.

These services are used to identify the following factors which are important to the prevention, treatment and management of physical health problems:

- Behavioral
- Cognitive
- Emotional
- Psychological
- Social

Covered health and behavior assessments and reassessments include:

- Health-focused clinical interviews
- Behavioral observations
- Clinical decision-making
- Evaluation of the patient's response to physical health problems, outlook and coping strategies, and adherence to treatment plans

Health behavior intervention services are intended to:

- Modify the psychological, behavioral, emotional, cognitive, and social factors relevant to and affecting the patient's physical health problems.
- Focus on promoting functional improvement, lessening the psychosocial and psychological obstacles to recovery, and improvement of the patient's coping skills related to the medical condition.
- Family interventions should emphasize active member or family engagement and participation.

If further evaluation of the member's psychological status is required to determine if a person has a mental illness or emotional disturbance, a mental health professional must conduct a mental health diagnostic assessment.

A Health behavior assessment does not qualify as a mental health diagnostic assessment; do not use to identify whether a member has or does not have a mental illness or emotional disturbance.

Preventive medicine counseling and risk factor reduction interventions are not covered.

Adult Consultation

Consultation provided by a psychiatrist, a psychologist, or an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker or licensed marriage and family therapist to Primary Care Providers, including pediatricians.

The consultation must be documented in the patient record maintained by the Primary Care Provider. Consultation provided without the Member being present is subject to federal limitations and data privacy provisions and must have the Member's prior consent

Adult and Adolescent Dialectical and Behavior Therapy

Dialectical Behavior Therapy intensive outpatient program (DBT IOP) is a treatment program that uses a combination of individualized rehabilitative and psychotherapeutic interventions. DBT IOP involves weekly individual therapy, weekly group skills training, telephone coaching as needed, and weekly consultation team meetings.

Mental health outpatient treatment benefits consistent with DHS guidelines and protocols, for dialectical behavior therapy (DBT) for Members who meet the eligibility criteria consistent with DHS guidelines for admission, continued treatment and discharge.

A recommendation for DBT IOP must be based on a comprehensive assessment, including: a diagnostic assessment, a functional assessment and a review of the member's prior treatment history by the DBT IOP team to determine that DBT IOP services are medically necessary.

Admission Criteria – Adults

- The member is 18 years or older
- The member meets one of the following two criteria:
 - The member has a diagnosis of borderline personality disorder
 - The member has multiple mental health diagnoses; exhibit behaviors characterized by impulsivity, intentional self-harm behavior or both; and be at significant risk of death, morbidity, disability or severe dysfunction across multiple life areas
- The member has mental health needs that cannot be met with other available community-based services or that need services provided concurrently with other community-based services
- The member is at risk of one of the following, as recorded in the member's record:
 - The member is in need for a higher level of care, such as hospitalization or partial hospitalization
 - The member has intentional self-harm (suicidal and non-suicidal) or risky impulsive behavior or be currently having chronic self-harm thoughts or urges (suicidal or non-suicidal) although the person has managed to not act on them. People with chronic self-harm thoughts and urges are at a greater risk of decompensation
 - The member has had mental health crisis
 - The member has decompensation of mental health symptoms; a change in member's composite LOCUS score, though not required, demonstrates risk of decompensation
- The member understands and is cognitively capable of participating in DBT as an intensive therapy program
- The member is able and willing to follow program policies and rules assuring the safety of self and others.

Admission Criteria – Children/Adolescents

- The member is 12-17 years old
- The member has a mental health diagnosis including, but not limited to, a substance-related and addictive disorder.
- The member has a documented assessment information showing functional deficits in three of five of problem areas:
- The member has emotional dysregulation
- The member has impulsivity (including avoidance)
- The member has interpersonal problems
- The member is a teenager and family challenges
- The member has reduced awareness and focus.

Continued Service Criteria

- The member is actively participating and engaged in the DBT program, its treatment components and its guidelines according to treatment team expectations
- The member has made demonstrable progress as measured against the member's baseline level of functioning before the DBT intervention. Examples of demonstrable progress include:
 - Decreased self-destructive behaviors
 - Decreased acute psychiatric symptoms with increased functioning in activities of daily living
 - Objective signs of increased engagement
 - Reduced number of acute care services, such as emergency department (ED) visits, crisis services and hospital admissions
 - Application of skills learned in DBT to life situations
 - Continues to make progress toward goals but have not fully demonstrated an internalized ability to self-manage and use learned skills effectively
- The member is actively working toward discharge, including concrete planning for transition and discharge
- The member has a continued need for treatment as indicated in the preceding continued-stay criteria and by ongoing documented evidence in the member's record.

Discharge Criteria

- The member has met individual treatment plan goals and objectives, or no longer meets continuing-stay criteria
- The member's thought, mood, behavior or perception has improved to a level for which a lesser level of service is indicated
- The member chooses to discontinue the treatment contract
- The provider concludes the member will no longer benefit from DBT services after a clinical assessment

- The provider will complete paperwork and refer the member to needed services

Service Delivery

Individual DBT

The DBT IOP must provide individual DBT by a qualified member of the certified team for the recommended duration of one hour per week. One of the following qualified team members may provide individual DBT:

- Mental health professional
- Mental health practitioner clinical trainee

Individual DBT is a combination of individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional coping behaviors and to reinforce the use of adaptive skillful behaviors by:

- Identifying, prioritizing and sequencing behavioral targets
- Treating behavioral targets
- Generalizing dialectical behavior therapy skills to members' natural environment by providing DBT IOP telephone coaching outside of scheduled office hours, 24 hours a day, 7 days per week while observing therapist's limits
- Measuring progress toward dialectical behavior therapy targets
- Managing crisis and life-threatening behaviors
- Helping members learn and apply effective behaviors in working with other treatment providers. If someone other than the individual therapist provides phone coaching, that person must be another member of the DBT IOP team trained in phone coaching protocol.

Group DBT

DBT IOP group skills training is a combination of individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce suicidal and other dysfunctional coping behaviors and restore function through teaching the following adaptive skills modules.

Adult DBT Training Skills Groups

Adult DBT Training Skills Groups consist of one cycle which includes the following four modules. The standard treatment for adults includes the completion of two cycles. One cycle lasts 24-26 weeks:

- Mindfulness
- Personal effectiveness
- Emotion regulation
- Distress tolerance

Adolescent DBT Training Skills Groups

Adolescent DBT Training Skills Groups consist of one cycle which includes the following five modules. The standard treatment for adolescents includes the completion of one cycle which lasts 24-26 weeks. Parenting DBT Skills Groups are included in the treatment for adolescents.

- Mindfulness
- Interpersonal effectiveness
- Emotional regulation
- Distress tolerance
- Walking the Middle Path (specific for parents and adolescents)

DBT IOP must provide group skills training by qualified members of the certified team for a minimum of two hours a week with the option to last up to two and a half hours. A combination of any of the following qualified team members may provide group skills training:

- Two mental health professionals
- One mental health professional co-facilitating with one mental health practitioner
- One mental health professional with one mental health practitioner clinical trainee

A mental health professional or mental health practitioner clinical trainee must determine the need for individual DBT skills training (delivered outside a group setting) and indicate that need.

Exclusions

Exclusionary services (Adults)

- DBT cannot be provided concurrently with the following services:

- Outpatient individual therapy
- Partial hospitalization
- Day treatment

Exclusionary services (Adolescents)

- DBT cannot be provided concurrently with the following services:
- Outpatient individual psychotherapy (including under CTSS umbrella)
- Partial Hospitalization
- CTSS Children’s Day Treatment
- Intensive Treatment in Foster Care
- Youth ACT

Children’s Mental Health Services

All Mental Health Professional services for Children up to age twenty-one (21), unless otherwise indicated, must be delivered by the MCO in a manner so as to establish or sustain the Member at a level of mental health functioning appropriate to the Member’s developmental level. This includes:

- Diagnostic assessment, and psychological testing with an explanation of findings to rule out MI or establish the appropriate MI diagnosis and develop the individual treatment plan. A diagnostic assessment must include the direct assessment of the Member. The MCO will require behavioral health Providers performing diagnostic assessments to screen all adolescent Members upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using screening tools on the IDDT web page: <https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/>.

Children’s Therapeutic Support Services

CTSS is a flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. CTSS addresses the conditions of emotional disturbance that impair and interfere with an individual’s ability to function independently. For children with emotional disturbances, rehabilitation means a series or multidisciplinary combination of psychiatric and psychosocial interventions to:

- Restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or
- Enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills, deficits or maladaptive skills acquired over the course of a psychiatric illness.

Psychiatric rehabilitation services for children combine psychotherapy to address internal psychological, emotional and intellectual processing deficits with skills training to restore personal and social functioning to the proper developmental level. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over time. CTSS services are delivered using various treatment modalities and combinations of services designed to reach measurable treatment outcomes identified in an individual treatment plan (ITP).

CTSS includes the following services:

- Psychotherapy (individual, family, and group)
- Skills training (individual, family, and group)
- Crisis assistance
- Mental health behavioral aide
- Direction of mental health behavioral aide

In addition, providers may be certified to provide:

- CTSS day treatment
- Mental health behavioral aide service

Admission Criteria

- The member has had a diagnostic assessment within 180 calendar days before the request or referral the member has received a diagnostic assessment from a qualified behavioral health professional, and meets any of the following criteria:

- Under age 18 and is diagnosed with an Emotional Disorder as indicated by an organic disorder of the brain or clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.
- Under age 18 and is diagnosed with a Severe Emotional Disturbance as indicated by at least one of the following:
 - The member has been admitted for inpatient or residential treatment within the last three years or is at risk of being admitted.
 - The member is a resident of Minnesota and is receiving inpatient or residential treatment for a behavioral health condition through the interstate compact.
- A behavioral health professional has determined that the member meets one of the following criteria:
 - The member has psychosis or clinical depression;
 - The member is at risk of harm to self or others as a result of a behavioral health condition;
 - The member has psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year;
 - A behavioral health professional has determined that the member has significantly impaired home, school or community functioning lasting at least one year or there is risk that impaired functioning will last at least one year.
- Be under 21 years old
- Have a diagnostic assessment that documents:
 - A primary diagnosis of an emotional disturbance for children under 18 years old or mental illness for young adults 18 through 20 years old
 - Medical necessity for CTSS
 - A completed CASII or ECSII
 - Between ages 18 through 20 and is diagnosed with mental illness or Serious and Persistent Mental Illness.
 - Serious and Persistent Mental Illness is indicated by the presence of a mental illness and at least one of the following:
 - The member has undergone two or more episodes of inpatient care within the preceding 24 months;
 - The member has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the previous 12 months;
 - The member has been treated by a crisis team two or more times within the preceding 24 months;
 - The member has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder; significant impairment in functioning; and has a written opinion from a behavioral health professional stating he or she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided;
 - The member has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued;
 - The member was eligible under one of the above criteria, but the specified time period has expired;
 - The member was eligible as a child with severe emotional disturbance, and the member has a written opinion from a mental health professional, in the last three years, stating that he or she is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in the above criteria, unless ongoing case management or community support services are provided.

AND

- The member's condition can be safely managed in an ambulatory setting. Examples include:
 - Imminent or current risk of harm to self or others, and/or property, if present, does not require 24-hour care;
 - The member's primary behavioral health condition or co-occurring medical and behavioral health conditions do not require 24-hour care.

AND

- Services are medically necessary as indicated by the following:
 - The service is consistent with the member's diagnosis and condition; and
 - Is recognized as the prevailing standard or current practice by the provider's peer group;
 - Is rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for a mother and child through the maternity period; or to achieve a level of physical or mental function; or
 - Is a preventive health service.

Service Delivery

Evaluation and Treatment Planning

- A qualified mental health professional completes a diagnostic assessment no more than 180 calendar days prior to the date of admission.
 - Diagnostic assessments for children under age 6 are typically interactive and may employ the use of physical aids and nonverbal communication when the child has not yet developed or has lost expressive communication skills needed to explain his/her symptoms and response to treatment; or does not possess the receptive communication skills needed to understand the provider via ordinary adult language.
 - For children assessing for functioning should be automatic in a diagnostic assessment. Functional assessment is present in every aspect of the assessment process, based on the recognition that a child's developmental progress in all areas (physiological, cognitive, emotional, and relational) determines the expected level of a child's functioning.
- The provider completes a functional assessment using the Child and Adolescent Intensity Instrument (CASII) and the Strengths & Difficulties Questionnaire (SDQ) for children ages 6-18, and the Early Childhood Service Intensity Instrument (ECSII) and the SDQ for children under 6 years old. These tools are used to gauge level of functioning over time.
 - The CASII and SDQ are administered at intake, every 6 months thereafter and at discharge
 - The ECSII and SDQ are administered at intake, every 3 months thereafter and at discharge.
- All services under CTSS must have an individual treatment plan prior to the start of service. The plan must be reviewed at a minimum every 90 calendar days.
 - The plan focuses on the member's vision of recovery and resilience, and documents the treatment strategy, the schedule of accomplishing the goals and objectives, and the responsible party for each treatment component.
 - The plan provides the member and family with a clear understanding of the services to be offered and how they will address the member's needs. Consequently, the member/member's parent or guardian takes part in developing the plan.
 - The plan must be achievable and based on the member's diagnosis and standards of practice for behavioral health treatment for people with that diagnosis. The objectives must be incremental and measurable. The ultimate goal is to reduce the duration and intensity of symptoms and services to the least intrusive level possible.
 - Best practice is that the service plan includes short term and long-term goals where short term goals are attainable in 30-90 calendar days.
- The plan for a child or adolescent:
 - Includes the member's/parent or guardian's expectations to help guide treatment planning and selection.
 - Reviews with the member/parent or guardian their understanding of concerns and the collaborative treatment process.
 - Includes mutually defined, comprehensible terms.
 - Addresses the member's strengths and vulnerabilities.
 - Indicates areas of uncertainty and makes recommendations on further assessments.
 - Communicates with the referring clinician, agencies, pediatricians, and schools (with parental consent).
 - Helps the member/parent or guardian identify services and facilitates referrals.
- The plan for Mental Health Behavioral Aide (MHBA) requires the following steps:
 - A behavioral health professional must approve services to be provided by a MHBA.
 - A behavioral health professional collaborates with the member's family, via parent teaming, to account for the needs of the child and family. The scope, duration, and frequency of services are considered.
- If a member is receiving MHBA services, and individual behavior plan is required in addition to the treatment plan. The behavior plan is a written plan of MHBA services developed by a behavioral health professional that includes detailed instructions for the aide on the services to be provided. It must also include:
 - Time allocated to each service;
 - Methods of documenting the member's behavior;
 - Methods of monitoring the child's progress in reaching objectives;
 - Goals to increase or decrease target behavior as identified in the treatment plan.
- Best practice is that the treatment plan includes short term and long-term goals where short term goals are attainable in 30-90 calendar days.
- The treatment plan includes specific and measurable objectives aimed at assisting the member with achieving the treatment goal, and interventions for each skill, knowledge, or resource objective.
- The treatment plan is informed by the findings of the diagnostic evaluation and the functional assessment.
- Service plans should be reviewed as frequently as needed, but at a minimum every 90 calendar days.
- When the diagnostic evaluation or functional assessment identifies potential risk of harm to self, others, and/or property, a safety plan is completed that includes:
 - Triggers;

- Current coping skills;
- Warning signs;
- Preferred interventions;
- Advance directives for adults receiving CTSS, when available.
- The program provides an effective system for reaching out to members who are not attending, becoming isolated, or who are hospitalized.

Discharge Planning

- Discharge planning is initiated as soon as appropriate after the onset of CTSS. As part of discharge planning, the provider solicits input from the member/member’s parent or guardian, service providers and significant others.
- Discharge planning anticipates the effects of termination in order to ensure a seamless transition from CTSS.
- Discharge planning also takes into consideration:
 - The reason that CTSS is being terminated.
 - Providing the member with reasonable notice that services are pending.
 - Identifying the member’s progress meeting their goals.
 - Identifying the services and supports needed to further assist the member with optimizing functioning and remaining in his/her community.
- For members remaining in the program’s geographic area of responsibility, the provider:
 - Shares the results of discharge planning and all pertinent information with other providers delivering services to the member prior to discharge.
 - Provides the member with information about:
 - Recommended self-help and community resources; and
 - How the member can resume CTSS.

For members moving outside the program’s geographic area of responsibility, the provider discusses the need for and availability of CTSS with the member. As needed, the provider assists the member with accessing CTSS in the member’s new service area. The case manager maintains contact with the member through the transition.

Children’s Intensive Treatment in Foster Care

Intensive Treatment in Foster Care (ITFC) is a comprehensive mental health service for children with significant mental health symptoms and impairments in their functional abilities who are living in a family foster care setting. ITFC establishes policies and practices for certification and coverage of mental health services for children who require intensive intervention without 24-hour medical monitoring (a Child and Adolescent Service Intensity Instrument (CASII) score of 4 or higher). Services includes psychotherapy, psychoeducation, clinical consultation and crisis assistance performed in addition to prescribed service requirements described in this section.

Intensive Treatment in Foster Care provides specific required service components to Children with mental illness residing in foster family settings:

- Psychotherapy provided by a mental health professional or a clinical trainee;
- Crisis assistance;
- Individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee
- Clinical care consultation provided by a mental health professional or a clinical trainee

Admission Criteria

To be eligible for ITFC, members must have an extended diagnostic assessment that clearly documents the necessity for the type of mental health service requested, including intensity of treatment and medical necessity. Members must also:

- Have a documented diagnosis of mental illness
- Be living in a family foster care setting
- Be between the ages of birth through 20
- Have a level-of-care evaluation completed by the placing county, tribe or case manager indicating that intensive intervention without 24-hour medical monitoring is required

A mental health professional or clinical trainee must complete the diagnostic assessment establishing eligibility for ITFC within 30 days of enrollment unless the client has a previous extended diagnostic assessment (within 180 days) that the client, parent and mental health professional agree still accurately describes the client’s current mental health functioning.

Service Delivery

ITFC services must be delivered at least three days per week for a total of six hours per week unless reduced units of service are documented on the treatment plan as part of transition to a lower level of care. The child's biological, foster and/or pre-adoptive families must be involved in treatment and service delivery to ensure a successful placement and permanency plan unless otherwise noted in the treatment plan. Services may be provided in the child's home, daycare, school or other community-based setting that is specified on the child's individualized treatment plan (ITP). Providers must also comply with the following requirements:

- Services must be developmentally and culturally appropriate for the child
- Services must be deemed medically necessary. Medical necessity for ITFC must focus on the child's current symptomology, functional impairments and placement needs within the family foster care setting.
- Each client receiving treatment services must have an extended diagnostic assessment within 30 days of enrollment unless the client has a previous extended diagnostic assessment (within 180 days) that the client, parent and mental health professional agree still accurately describes the client's current mental health functioning.
- Each client must be assessed for a trauma history using a standardized tool. The results must be incorporated into the client's individual treatment plan's goals and objectives.
- Documentation must be requested for all treatment and assessments the client has received from previous and current mental health, school and physical health providers. This documentation must be reviewed and incorporated into the diagnostic assessment, team consultation and treatment planning process.
- Each client must have a crisis assistance plan within 10 days of initiating services and must have access to clinical phone support 24 hours per day, 7 days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.
- Each client must have an individualized treatment plan that is reviewed, evaluated and signed every 90 days using the team consultation and team treatment planning process. Services must be delivered utilizing a treatment team approach, meaning services must be provided in continual collaboration and consultation with the child's medical providers, mental health professionals, educational and social services case managers and any other professional working with the child.
- Services must be delivered in continual collaboration and consultation with professionals prescribing any psychotropic medications. Members of the treatment team must be aware of the medication regimen and potential side effects.
- Transition planning must begin with the first treatment plan and be addressed throughout treatment to support the child's permanency plan and post discharge mental health service needs.

Children's Mental Health Crisis Response Services

Crisis Response Services are immediate face-to-face assessment services by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an inpatient hospital setting.

Admission Criteria

- The member is under the age of 21;
- The member is experiencing a mental health crisis or emergency
- The member meets the criteria for emotional disturbance (0-18) or mental illness (18-21)

Crisis Assessment

A crisis assessment is an immediate, face-to-face evaluation by a physician, mental health professional or practitioner to determine the member's presenting situation and identify any immediate need for emergency services. The crisis assessment is meant to:

- Provide immediate intervention to relieve the member's distress based on a determination that the child's behavior is a serious deviation from his or her baseline level of functioning
- Evaluate, in a culturally appropriate way and as time permits, the member's current:
 - Life situation

- Sources of stress
- Symptoms
- Risk behaviors
- Mental health problems
- Strengths and vulnerabilities
- Cultural considerations
- Support network
- Level of functioning
- Conduct the crisis assessment in one of the following locations:
 - The member's home
 - The home of a family member
 - Another community location
- Determine the need for crisis intervention services, or referrals to other resources, based on the assessment.

Crisis Intervention

With the member, develop, document and implement an initial crisis intervention treatment plan within 24 hours after the initial face-to-face intervention to reduce or eliminate the crisis. The treatment plan must be culturally and linguistically appropriate for the member.

- List the member's needs and problems identified in the crisis assessment
- Identify:
 - Frequency and type of services to be provided
 - Measurable short-term goals
 - Specify objectives directed toward the achievement of each goal
 - Note cultural considerations
 - Recommend needed services, including crisis stabilization
 - Refer to appropriate local resources, such as:
 - County social services agency
 - Mental health services
 - Local law enforcement
 - Write clear progress notes of the outcome of goals
 - Identify frequency and type of services to be provided
 - Coordinate the planning of other services with the member's case manager if they have one
 - Update the crisis intervention treatment plan as needed to reflect changes in goals and services.

If the member shows positive change in a baseline of functioning or a decrease in personal distress:

- Make (and document) a referral to less-intensive mental health services
- Document short-term goals that have been met and when no further crisis intervention services are needed
- If the member is unable to follow-up with a referral, the crisis response provider must link the member to the service and follow-up to ensure that the member is receiving the service

The child or the parent or guardian must sign the crisis plan. If the child and family refuse to approve and sign the plan, the team must note the refusal and the reasons for the refusal in the treatment plan. A mental health professional must approve and sign the treatment plan. Give a copy of the treatment plan to the member.

If services continue 24 hours after the beginning of the face-to-face intervention:

- A mental health professional must contact the member face-to-face, on the second day, to provide services and update the crisis treatment plan
- The mental health professional is not required to be the same professional who was supervising the service when the face-to-face crisis intervention began

Crisis Stabilization

Crisis stabilization services are mental health services, provided after crisis intervention, to help the member return his or her functioning to the level it was before the crisis.

- Provide stabilization services:
 - In the community
 - Based on the crisis assessment and intervention treatment plan
 - Consider the need for further assessment and referrals
 - Update the crisis stabilization treatment plan

- Provide supportive counseling
- Conduct skills training
- Collaborate with other service providers in the community
- Provide education to the member's family and significant others regarding mental illness and how to support the member

Crisis Stabilization Treatment Plan

With the member, develop a crisis stabilization treatment plan within 24 hours of beginning services. The crisis stabilization treatment plan, at a minimum, must include:

- Problems identified in the assessment
- Measurable short-term goals and tasks to be achieved, including time frames for achievement
- Specific objectives directed toward achieving each goal
- Clear progress notes about outcomes of goals
- List of member's strengths and resources
- Documentation of participants involved
- A crisis response action plan if another crisis should occur
- Frequency and type of services initiated, including a list of providers, as applicable

A mental health professional and the member must approve and sign the treatment plan. If the member refuses to approve and sign the plan, note the refusal and the reason(s) for the refusal in the treatment plan. Give a copy of the plan to the member.

Children's Clinical Care Consultation

Clinical Care Consultation means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family. Clinical Care Consultation is for members up to age 21 diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional.

Admission Criteria

- The member is between the ages of 0-21
- The member has a diagnosis of mental illness determined by a diagnostic assessment that includes both of the following:
 - The member meets the definition of complex, as defined in the Minnesota Rules 9505.0372, Subpart 1, C, or co-occurs with other complex and chronic health conditions
 - The member requires consultation to other providers working with the child to effectively treat the condition.
- Examples of appropriate providers and educators who may receive a consultation include the following:
 - Home health care agencies
 - Child-care providers
 - Children's mental health case managers
 - Educators
 - Probation agents
 - Adoption or guardianship workers
 - Guardians' ad litem
 - Child protection workers
 - Pediatricians
 - Nurses
 - After-school program staff
 - Mentors

Service Delivery

Document the medical necessity for mental health clinical care consultation in the diagnostic assessment. The diagnostic assessment must describe how the child meets criteria for a complex mental health condition or which complex or chronic health conditions co-occur with the child's mental health condition. This description may be included in the initial assessment, in an addendum to the diagnostic assessment, or within the narrative portion of the individualized treatment plan (ITP) review process. Submit this information with any request for authorization.

Individualized Treatment Plan

Document in the ITP the specific interventions, describing how the mental health professionals will use mental health clinical care consultation to treat the child's mental illness.

Progress Notes

Document all mental health clinical care consultation in progress notes, including the following information:

- Mode of performance (phone or face-to-face)
- Date of service
- Start and stop time of service
- Intervention
- Person consulted (name, position, relationship to recipient)
- Reason for consultation
- Plan and action for next steps
- Date documented in the client's record

For consultations performed by clinical trainees, the clinical supervisor must review and approve the recipient's progress notes according to the clinical trainee's supervision plan.

Noncovered Services

Mental health clinical care consultation does not include the following:

- Communication between the treating mental health professional and a person under the clinical supervision of the treating mental health professional
- Written communication between providers
- Reporting, charting and record keeping (These activities are the responsibility of the provider)
- Mental health services not related to the recipient's diagnosis or treatment for mental illness
- Communication provided during the performance of any of the following mental health services:
 - Mental health case management
 - In-reach services
 - Youth ACT
 - Intensive treatment services in foster care.

Children's Family Psychoeducation Services

Family Psychoeducation Services provided by a mental health professional or a clinical trainee who determines it medically necessary to involve family members in the Child's care to explain, educate, and support the Child and family in understanding a Child's symptoms of mental illness, the impact on the Child's development, and needed components of treatment and skill development to prevent relapse and the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience. It supports the recipient and family in understanding these factors:

- The recipient's symptoms of mental illness
- The impact on the recipient's development
- Needed components of treatment
- Skill development

Admission Criteria

- Eligible recipients of family psychoeducation must have a diagnosis of emotional disturbance or mental illness as determined by a diagnostic assessment and be under age 21.
- The diagnostic assessment must describe how the child meets criteria for a mental health condition. You may include this description in the initial assessment, in an addendum to the diagnostic assessment, or within the narrative portion of the individualized treatment plan (ITP) review process.

Service Delivery

Family psychoeducation services for any of the following in outpatient settings when directed toward meeting the identified treatment needs of each participating recipient as indicated in the recipient's treatment plan:

- The recipient (individual)
- A recipient's family (with or without the recipient present)
- Groups of recipients (peer group)
- Multiple families (family group)

These services may be provided via telemedicine. Refer to the Telemedicine Delivery of Mental Health Services section of the MHCP Provider Manual.

Family

The recipient's family includes people the recipient, parent or guardian identify as being important to the recipient's mental health treatment. Family may include, but is not limited to the following:

- Parents or caregivers
- Siblings
- Children
- People related by blood or adoption
- People who are presently living together as a family unit

Peer Group

A peer group must be at least three, but no more than 12 recipients. The following criteria for groups apply:

- For groups of three to eight recipients, at least one mental health professional or clinical trainee must conduct the group.
- For groups of nine to 12 recipients, any combination of at least two mental health professionals or clinical trainees must co-conduct the group

Family Group

The following criteria applies for family groups:

- A family group must be at least two but no more than five families.
- For groups of five to 10 families, any combination of at least two mental health professionals or clinical trainees must co-conduct the group

Family psychoeducation does not include the following:

- Communication between the treating mental health professional and a person under the clinical supervision of the treating mental health professional
- Written communication between providers
- Reporting, charting, and record keeping (These activities are the responsibility of the provider.)
- Mental health services not related to the recipient's diagnosis or treatment for mental illness
- Communication provided while performing any of the following mental health services:
 - Mental health case management
 - In-reach services
 - Youth ACT
 - Intensive treatment services in foster care

Authorization Requirements

Family psychoeducation units or sessions are subject to the same calendar year, cumulative limits as psychotherapy. These limits are as follows for family psychoeducation:

- 26 hours of individual psychoeducation per calendar year, cumulative
- 26 sessions of family psychoeducation per calendar year, cumulative
- 52 sessions of peer group psychoeducation per calendar year, cumulative
- 10 sessions of family group psychoeducation per calendar year, cumulative
- A maximum of 4 units of family psychoeducation, per individual in one day
- A maximum of 1 session (or 4 units) of family psychoeducation, per family in one day
- A maximum of 1 session (or 4 units) of family psychoeducation, per family in a multifamily group in one day
- A maximum of 1 session (or 4 units) of family psychoeducation, per individual in a group setting in one day

Children's Certified Peer Specialists

Certified Family Peer Specialists provide nonclinical family peer support, building on the strengths of families and helping them achieve desired outcomes, collaborate with others providing care or support to the family, provide advocacy, promote the individual family culture in the treatment milieu, link parents to other parents in the community, offer support and encouragement, assist parents in developing coping mechanisms and problem-solving skills, promote resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services, establish and provide peer led parent support groups, and increase the Child's ability to function better within the Child's home, school and community by educating parents on community resources, assisting with problem-solving, educating parents on mental illness, and provide support for mobile mental health crisis intervention

Admission Criteria

To be eligible for CFPS services, a child or youth must be receiving any one of the following services:

- Inpatient hospitalization
- Partial hospitalization
- Residential treatment
- Treatment foster care
- Day treatment
- Children's therapeutic services and supports
- Crisis services programs

Service Delivery

The following activities are covered by CFPS services:

- Education to develop coping and problem-solving skills
- Non-adversarial advocacy
- Collaboration with others providing care or support to family
- Connection to other families, parents, community and school resources
- Identifying strategies and services that help promote resiliency and develop natural supports
- Establish and lead parent support groups
- Support parental self-advocacy skills, including accompanying parents to IEP and treatment planning meetings and community events

Documentation of medical necessity of CFPS services occurs within the diagnostic assessment and individual treatment plan. The diagnostic assessment describes how the child or youth meets criteria for emotional disturbance or severe emotional disturbance. Within the child or youth's individualized treatment plan, specific interventions describing how the CFPS services will be utilized to treat the child or youth's mental illness are documented.

The following services are not covered as CFPS services:

- Transportation
- Services performed by volunteers
- Household tasks, chores or related activities such as laundering clothes, moving, housekeeping and grocery shopping
- Time spent "on call" and not delivering services to recipients
- Job-specific skills services such as on-the-job training
- Case management
- Outreach to potential recipients
- Services to family members
- Room and board
- Service by providers that are not approved to provide CFPS services
- CFPS services that are included in the daily rate may not be billed separately

Children's Assertive Community Treatment

Assertive Community Treatment For Youth provides intensive nonresidential rehabilitative mental health services by a multidisciplinary staff using a team approach consistent with assertive community treatment adapted for Members eight (8) years of age or older and under twenty-six (26) years of age, with a serious mental illness or co-occurring mental illness and substance abuse addiction that requires services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

Admission Criteria

Members must be 8 years old or older and under 26 years of age and have:

- Diagnosis of serious mental illness or co-occurring mental illness and substance abuse addiction
- A level of care determination of Level 4 on the CASII for ages 8 through 18 and Level 4 on the LOCUS for ages 19 through 26. The level of care must indicate a need for intensive integrated intervention without 24-hour monitoring.
- Functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job
- Likely need for services from the adult mental health system during adulthood.
- Have a current diagnostic assessment indicating the need for intensive nonresidential rehabilitative mental health services

Service Delivery

The Youth ACT/IRMHS team provides the following services:

- Individual, family and group psychotherapy
- Individual, family and group skills training
- Crisis assistance
- Medication management
- Mental health case management
- Medication education
- Care coordination with other care providers
- Psychoeducation to, and consultation and coordination with, the member's support network (with or without the member present)
- Clinical consultation to the member's employer or school
- Coordination with, or performance of, crisis intervention and stabilization services
- Assessment of member's treatment progress and effectiveness of services using outcome measurements
- Transition services
- Integrated dual disorders treatment
- Housing access support

Services must meet the specific cultural needs of the client.

A core Youth ACT/IRMHS team must maintain at least four full-time equivalent direct care staff which must include a:

- Mental Health Professional
- Licensed alcohol and drug counselor trained in mental health interventions
- Certified Peer Specialist
- And one of the following, credentialed to prescribe medications:
 - Advanced practice registered nurse certified in psychiatric or mental health care
 - Board-certified child and adolescent psychiatrist

An individual treatment team must serve youth who are either:

- At least 8 years old or older and under 16 years old; or
- At least 14 years old or older and under 26 years old

The treatment team must have specialized training in providing services to the specific age group of youth that the team serves.

Members and or family members must receive at least three face-to-face contacts per week that meet the following criteria:

- Face-to face contacts must total a minimum of 85 minutes of service
- The treatment team must use team treatment, not an individual treatment model.
- Services must be age-appropriate and meet the specific needs of the client.
- The initial functional assessment must be completed within 10 days of intake and updated at least every six months or prior to discharge from the service, whichever comes first.

Each client must have an individualized treatment plan. The treatment plan must:

- Be based on the information in the client's diagnostic assessment and baselines;

- identify goals and objectives of treatment, a treatment strategy, a schedule for accomplishing treatment goals and objectives and the individuals responsible for providing treatment services and supports;
- Be developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;
- Be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessments and treatment planning;
- Be reviewed at least once every six months and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment;
- Be signed by the clinical supervisor and by the client or by the client's parent or other people authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;
- Be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan.

Children's Partial Hospitalization

Partial Hospitalization is a time-limited, structured program provided in an outpatient hospital setting or a Medicare-certified community mental health center (CMHC). Partial hospitalization provides person- and family-centered treatment by a multidisciplinary team under the direction of a physician.

Partial hospitalization includes, at a minimum, one session of individual, group or family psychotherapy and two or more other services.

To be consistent with Medicare recommended standards:

- Provide at least 4 days, but not more than 5 out of 7 calendar days, of partial hospitalization program services
- Ensure a minimum of 20 service components and a minimum of 20 hours in a 7 calendar-day period
- Provide a minimum of 5 to 6 hours of services per day for an adult aged 18 years or older
- Provide a minimum of 4 to 5 hours of services per day for a child under age 18 years

Admission Criteria

To receive partial hospitalization program services, an MHCP member must:

- Be eligible for Minnesota Health Care Programs
- Be experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission
- Have the ability to participate in treatment
- Have appropriate family or community resources needed to support and enable the member to benefit from less than 24-hour care
- Be admitted to PHP under the care of a Physician who certifies the need for Partial Hospitalization, stating the member would otherwise require inpatient psychiatric care, if PHP were not provided.
- Have completed an ECSII and SDQ for children aged 5 years and younger
- Have completed a CASII and SDQ for children 6 years of age and older
- Have a completed LOCUS assessment with a Level 4 indication for adults aged 18 and older

Children's Psychiatric Residential Treatment Facility

Psychiatric Residential Treatment Facilities (PRTFs) deliver services under the direction of a physician, seven days per week, to residents and their families, which may include individual, family and group therapy. Children and youth under age 21 are eligible based on medical necessity, as determined by the Minnesota Department of Human Services Behavioral Health Division (BHD). PRTFs are not considered Institutions for Mental Disease (IMDs).

The purpose of treatment in a PRTF is to provide an inpatient level of care to improve an individual's condition to the point where inpatient care is no longer necessary. Comprehensive discharge planning is essential for individuals to successfully transition to home, school and community as soon as possible. Discharge planning begins at the time of admission and requires coordination with the individuals, their families and community-based service providers. The individual plan of care must include discharge plans and coordination of services to ensure continuity of care with the beneficiary's family, school and community upon discharge.

Admission Criteria

Members meet all the following criteria to be eligible for admission to a PRTF (initial and concurrent services):

- Be under 21 at time of admission
- Services may continue until individual meets discharge criteria or reaches 22 years of age, whichever occurs first
- Have a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM), as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others
- Have functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home or job
- Have an inability to adequately care for one's physical needs; or have caregivers, guardians or family members who are unable to safely fulfill the individual's needs
- Require psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed
- Have utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed
- Have been referred for treatment in a PRTF facility by a qualified mental health professional (MHP)

Continued Stay Criteria

The plan of care every is updated every 90 days to determine continued medical necessity for treatment and to approve an additional 90 days of treatment. This includes whether the member continues to meet criteria for PRTF services and is making progress towards treatment goals and discharge. The following is required for authorization:

- The PRTF must submit an updated plan of care 10 days before the end of the current authorization.
- The PRTF must submit an updated plan of care anytime there are changes made to a plan of care within 14 days.

The PRTF must submit an updated plan of care within 14 days when the provider does any of the following:

- Requests additional days beyond the initial 90 days of treatment
- Adds or changes arranged services to the plan of care that require authorization
- Adds or changes concurrent services to the plan of care as part of the discharge plan
- Adds or changes therapeutic leave days

Changes in Primary Diagnosis

- The PRTF must submit an updated plan of care to the BHD when the provider changes or updates a primary diagnosis within 14 days of the change.

Discharge from PRTF

- PRTF provider must notify BHD within 48 hours of discharge by emailing discharge summary and updated plan of care

Service Delivery

PRTF services include all of the following:

- Individual therapy provided a minimum of twice per week
- Family engagement activities provided a minimum of once per week
- Consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff or other support planners
- Coordination of educational services between local and resident school districts and the facility
- 24-hour nursing services
- Direct care and supervision, supportive services for daily living and safety, and positive behavior management
- Discharge planning

Admission and the first 90 days of treatment are authorized. Providers must resubmit it after the initial 90 days and then every 90 days thereafter for the duration of treatment.

- Certification of need for care: A physician, physician assistant or nurse practitioner, acting within the scope of practice as defined by state law and under the supervision of a physician, must verify a member's need for continued placement at an inpatient hospital level of care. The initial certification consists of the admitting physician's written order and plan of care documented in the medical record.

- The individual plan of care is developed by the PRTF interdisciplinary treatment team following completion of a diagnostic evaluation. The individual plan of care must include an integrated program of therapies, activities and experiences designed to meet treatment goals.
- A physician's signature is required on the plan of care for initial admissions and continued stay reviews to satisfy Inpatient Hospital Authorization need for care certification or recertification requirements.
- PRTF providers are responsible for developing internal policies and procedures for determining if members requesting emergency admission meet the required medical necessity of a PRTF in the event of emergency admissions.

PRTF services must be provided under the direction of a physician, and include psychiatric assessment; individual, family and group therapy; psychotropic medication; and other specialty services that are person-centered, trauma-informed and culturally responsive. Expectations include a written individual plan of care, review of the plan of care every thirty (30) days, and a discharge plan.

Early Intensive Developmental & Behavioral Intervention

The Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit offers medically necessary services and supports to people under the age of 21 with autism spectrum disorder (ASD) or related conditions.

The purpose of the EIDBI benefit is to:

- Educate, train and support parents and families of people with ASD and related conditions
- Promote people's independence and participation in family, school and community life
- Improve long-term outcomes and quality of life for people and their families

The EIDBI benefit covers the following services:

- Comprehensive multi-disciplinary evaluation (CMDE)
- Individual treatment plan (ITP) development and progress monitoring
- Coordinated care conference
- Intervention – individual, group and higher intensity
- Intervention observation and direction
- Family or caregiver training and counseling
- Telehealth
- Travel time

Admission Criteria

A person is eligible to receive EIDBI services if he or she meets all of the following criteria:

- Has autism spectrum disorder (ASD) or a related condition
- Has had a comprehensive multi-disciplinary evaluation (CMDE) that establishes his or her medical need for EIDBI services
- Is enrolled in Medical Assistance (MA), MinnesotaCare, Minnesota Tax Equity and Fiscal Responsibility Act (TEFRA) or other qualifying health care programs
- Is under age 21

A person has a medical need to begin EIDBI services if they meet all of the following criteria:

- The person's symptoms are present in the early developmental period, or the symptoms either:
 - May not have fully manifested until social demands exceeded limited capacities
 - Were masked by learned strategies in later life
- The person's behaviors persist in frequency, intensity and duration across environments
- The person's behaviors either:
 - Present a health or safety risk to self or others
 - Cause clinically significant impairment in the person's functional participation in the home or community such that typical family and community activities are regularly disrupted or unmanageable
- Based on the CMDE, the person requires 10 or more hours per week of EIDBI services (unless there is a clinical rationale for an exception)
- The CMDE provider determines the interventions covered by EIDBI services will appropriately target the core characteristics of the person with ASD or a related condition.

Younger than age five

- If the person is younger than age five, the person may not have an ASD or related condition diagnosis but may still meet medical necessity criteria. For more information, see exception to diagnostic criteria on EIDBI – Eligibility for EIDBI services.

Continued Stay Criteria

All of the following criteria must be met before EIDBI services are reauthorized:

- The person continues to meet medical necessity criteria for EIDBI services, as documented in the CMDE
- The ITP documents:
 - Progress monitoring on developmentally appropriate goals and objectives that are increasingly generalized across environments and people
 - Any changes or updates to the parent/primary caregiver's input into the goals/objectives and progress monitoring updates
 - Any changes or updates to the parent/primary caregiver's preference for participation in treatment and family/caregiver training and counseling
- The QSP determines the person will continue to benefit from the prescribed EIDBI services based on documented progress
- The progress on overall goals documented in the ITP indicates reasonable progress is expected to continue, or EIDBI services are required to ensure skills are maintained
- The parent or legal guardian signs the ITP to document continued agreement with and consent for EIDBI services.

Discharge Criteria

A change in the intensity level of EIDBI services (i.e., increase or decrease) may be determined medically necessary for one or more of the following reasons:

- The person starts school
- The person transitions from EIDBI to other services
- There is a significant change in the family
- There is an increase or decrease in other related services
- The CMDE provider or QSP recommends a change in the intensity level of EIDBI services and documents rationale
- The parent or legal representative requests a change in the intensity level of EIDBI services and the CMDE provider or QSP documents supportive rationale
- The person received the recommended treatment amount and did not make progress.

Termination of EIDBI services may be determined medically necessary for one or more of the following reasons:

- The person has achieved maximum benefit from EIDBI services, as documented by measurable progress on and generalization of goals and objectives across environments and people
- The person no longer meets medical necessity criteria for EIDBI services
- EIDBI services make the person's symptoms persistently worse
- The person is not making progress toward individual treatment goals, or EIDBI services are not required to ensure skills are maintained

(Note: This lack of progress is demonstrated by the absence of any documented, sustainable, generalized and measurable progress.)

- The person has not shown signs of or the provider does not reasonably expect the person to show signs of measurable progress within 12 months of the initial ITP development. This is demonstrated by both:
 - Lack of documented progress during the ITP update
 - Adjustments to the treatment plan that have not benefited the person
- The parent or legal guardian requests termination of services
- The CMDE provider or QSP recommends a termination of services because the person would likely benefit from another service or be served more appropriately by less intensive forms of treatment.

Service Delivery

Every Early Intensive Developmental and Behavioral Intervention (EIDBI) service must address the person's medically necessary treatment goals and be targeted to develop, enhance or maintain the person's developmental skills to improve their:

- Functional communication (receptive and expressive)
- Social or interpersonal interaction skills
- Interfering or complex behaviors
- Self-regulation
- Cognitive functioning
- Learning and playing skills

- Safety skills
- Self-care skills.

Once the person is determined eligible for EIDBI services, the provider agency must develop an individualized treatment plan (ITP). Before the person can start or continue receiving services, they must have a completed ITP and Progress Monitoring signed and dated by the following people:

- QSP who completed the ITP
- Caregiver/guardian
- Interpreter (if applicable).

Person-centered planning ensures EIDBI services:

- Respond to the identified needs, interests, values, preferences and desired outcomes of the person and legal representative, as outlined in the CMDE and ITP
- Respect the person’s rights, history, dignity and cultural background (see EIDBI – Rights and responsibilities)
- Allow inclusion and participation in the person’s community.

The person may receive EIDBI services in the following settings:

- Center
- Clinic
- Home or community environment (e.g., school)
- Office.

The treatment recommendation should be at least 10 hours per week of EIDBI services. For a person older than age seven, the treatment recommendation should not exceed 20 hours per week of EIDBI services.

Consider the following when recommending treatment:

- The family’s primary spoken language, culture, preferences, goals and values
- Other services the person or family receives or might need
- The parent’s or primary caregiver’s preferences for the person’s EIDBI treatment intensity, their training and counseling intensity and level of involvement in the person’s treatment
- Summary results for ASD or related conditions core deficits (recorded in section F of the CMDE, DHS-7108; see EIDBI – How to complete CMDE Medical Necessity Summary Information, DHS-7108)
- Time the person spends in school or other therapy services.

Framework

EIDBI – Medical necessity treatment determination guidelines provides a framework to make treatment recommendations based on:

- The person’s age
- The summary results for ASD and related conditions core characteristics (i.e., “impact scores”).

Exceptions

Some circumstances may allow for exceptions to medical necessity treatment guidelines.

Fewer than 10 hours

The review agent may approve fewer than 10 hours of EIDBI services per week if at least one of the following situations is true:

- The person is younger than age three
- The parent/primary caregiver requests fewer hours
- The CMDE provider recommends fewer than 10 hours per week of EIDBI services and documents rationale in CMDE Medical Necessity Summary Information, DHS-7108
- The Individual Treatment Plan (ITP), DHS-7109 documents other services the person receives that indicate a need for fewer than 10 hours per week of EIDBI services.
- Once the provider submits DHS-7108 and DHS-7109 for authorization, the review agent will evaluate the rationale and determine if it is medically appropriate for the person to receive fewer than 10 hours per week of EIDBI services.

More than 20 hours for a person older than age seven

The review agent may approve more than 20 hours of EIDBI services per week for a person older than age seven if at least one of the following situations is true:

- The person needs crisis intervention
- The person is at risk of out-of-home placement due to challenging behaviors
- The person needs an intensive boost of intervention for a short period of time based on a developmental or environmental transition or change in circumstances

- The person did not have access to EIDBI services early in life
- The CMDE provider recommends more than the 20 hours of EIDBI services per week and documents rationale in CMDE Medical Necessity Summary Information, DHS-7108
- The qualified supervising professional (QSP) recommends more than the 20 hours of EIDBI services per week and documents rationale in Individual Treatment Plan (ITP), DHS-7109.
- Once the provider submits DHS-7108 and DHS-7109 for authorization, the review agent will evaluate the rationale and determine if it is medically appropriate for the person to receive more than 20 hours per week of EIDBI services.

Adults & Children's Targeted Case Management

Mental Health Targeted Case Management Adult mental health targeted case management (AMH-TCM) and children's mental health targeted case management (CMH-TCM) services help adults with serious and persistent mental illness (SPMI) and children with severe emotional disturbance (SED) gain access to medical, social, educational, vocational and other necessary services connected to the person's mental health needs. Targeted case management (TCM) services include developing a functional assessment (FA) and individual community support plan (ICSP) for an adult and an individual family community support plan (IFCSP), referring and linking the person to mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Case management services involve:

- Developing a functional assessment and individual community support plan;
- Referring and assisting the member with obtaining needed mental health and other services;
- Ensuring coordination of services; and
- Monitoring the delivery of services.

Admission Criteria

- The member has had a diagnostic assessment within 180 calendar days before the request or referral for case management services and the diagnostic assessment has determined that the member is eligible.

AND

- Notwithstanding this requirement, a member is eligible for case management services if all of the following criteria are met:
 - The member requests or is referred for and accepts case management services.
 - A diagnostic assessment is refused.
 - The case manager determines that the person is a child with Severe Emotional Disturbance or an adult with a Serious and Persistent Mental Illness.
 - The member obtains a diagnostic assessment within 4 months of the day the member first receives case management services.

AND

- Adults
 - Age 18 or older and either of the following;
 - Member has a Serious and Persistent Mental Illness as indicated by at least one of the following:
 - Two or more episodes of inpatient care for a mental health condition within the past 24 months;
 - Continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the past 12 months;
 - Treatment by a crisis team two or more times within the past 24 months;
 - A diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, major depression or borderline personality disorder which causes significant functional impairment; a mental health professional has submitted a written opinion stating that the member is likely to require inpatient or residential treatment unless community support program services are provided;
 - In the last three years a court has committed the member as a mentally ill person under Minnesota statutes, or a commitment has been stayed or continued;
 - The person was eligible under one of the above criteria; but the specified time period has expired.
 - The member is determined by a county or tribe to appear eligible for case management but due to the person's initial refusal to participate in the diagnostic assessment, the member's eligibility determination can't be completed; eligibility is limited to 90 calendar days.

OR

- Children and Adolescents

- Under age 18 and the member has a Severe Emotional Disturbance as indicated by at least one of the following:
 - The member has been admitted for inpatient or residential treatment within the last three years or is at risk of being admitted.
 - The member is a resident of Minnesota and is receiving inpatient or residential treatment for a behavioral health condition through the interstate compact.
 - A mental health professional has determined that the member meets one of the following criteria:
 - The member has psychosis or clinical depression;
 - The member is at risk of harm to self or others as a result of a behavioral health condition;
 - The member has psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year;
 - A behavioral health professional has determined that the member has significantly impaired home, school or community functioning lasting at least one year or there is risk that impaired functioning will last at least one year.
- An adolescent who has received MH-TCM services within 90 days prior to turning 18 may qualify for AMH-TCM.

AND

- All Members
 - The member requires assistance accessing needed medical, social, educational, vocational, financial and other necessary services as they relate to individual's mental health needs.

AND

- The member's condition can be safely managed in an ambulatory setting. Examples include:
 - Imminent or current risk of harm to self or others and/or property, if present, does not require 24-hour care;
 - The member's primary behavioral health condition or co-occurring medical and behavioral health conditions do not require 24-hour care.

AND

- Services are medically necessary as indicated by the following:
 - The service is consistent with the member's diagnosis and condition; and
 - Is recognized as the prevailing standard or current practice by the provider's peer group;
 - Is rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for a mother and child through the maternity period; or to achieve a level of physical or mental function; or Is a preventive health service.

Discharge Criteria

- A mental health professional who has provided behavioral health services to the member furnishes a written opinion that the member no longer meets the eligibility criteria.
OR
- The member/member's parent or guardian and the case manager decide that the member no longer requires case management services.
OR
- The member/member's parent or guardian refuse further case management services.
OR
- The member is not in a residential treatment facility, regional treatment center, or acute care hospital in a county outside the county of financial responsibility; no face-to-face contact has occurred between the case manager and the member because the member has failed to keep an appointment or refused to meet with the member.
- Adults: no face-to-face contact has occurred for 180 consecutive calendar days.
- Children and Adolescents: no face-to-face contact has occurred for 90 consecutive calendar days.
OR
- Continued stay criteria are otherwise no longer met.

Service Delivery

Evaluation and Treatment Planning

- Within 30 calendar days after first meeting with the member, the case manager:
 - Reviews the diagnostic assessment.
 - Assesses the member's strengths, resources, supports, needs, functioning, health problems and conditions, safety, vulnerability, and injury risk. The assessment includes the member's family and other natural resources whenever possible.

- Screens for drug and alcohol use.
- Reviews documentation of the member's status, cultural considerations, and functional status in the following domains:
 - Behavioral health symptoms and needs as presented in the diagnostic assessment;
 - Use of drugs and alcohol;
 - Vocational and educational functioning;
 - Social functioning, including use of leisure time;
 - Interpersonal functioning, including relationships with the member's family;
 - Self-care and independent living capacity;
 - Medical and dental health;
 - Financial assistance needs;
 - Housing and transportation needs; and
 - Other needs and problems.
- For adult members, completes the LOCUS to determine resources and resource intensity needs.
- Develops a support plan in collaboration with the member/member's parent or guardian that includes:
 - The member's goals and the specific services;
 - Activities for accomplishing each goal;
 - Schedule for each activity;
 - Frequency of face-to-face contact with the case manager occurring at least monthly except for limited situations such as less frequent contact prior to terminating case management as part of determining the aptness of case closure.
- The case manager's interactions with the member/member's parent or guardian include the following which are aimed at helping the member acquire resources in support of the member's goals:
 - Connect the member with informal natural supports;
 - Link the member with the local community, resources, and service providers;
 - Refer the member to available health treatment and rehabilitation services.
 - The case manager collaborates with the member/member's parent or guardian, other providers, resources, and service representatives to:
 - Ensure service coordination by reviewing programs and services for accountability, verification that everyone is addressing the same purposes stated in the service plan so that the member is not exposed to discontinuous or conflicting interventions and services.
 - Determine achievement of goals/objectives in the member's service plan to see if goals are being achieved according to the service plan's projected timelines and continue to fit the recipient's needs.
 - Determine service and support outcomes through ongoing observations which can trigger reconsideration of the plan and its recommended interventions when the service plan is not accomplishing its desired effects.
 - Identify emergence of new needs by staying in touch with the member to identify problems, modify plans, ensure the recipients has resources to complete goals, and track emerging needs.
- The case manager reviews, and if necessary, revises, the support plan at least every 180 calendar days, and at the same time reviews the member's functional assessment. The support plan may be reviewed more frequently such as when:
 - The member's service needs change;
 - The member/member's parent or guardian requests that the service plan be reviewed every 90 calendar days.

Discharge Planning

- Discharge planning is initiated as soon as appropriate after the onset of case management. As part of discharge planning, the case manager solicits input from the member/member's parent or guardian, service providers and significant others.
- Discharge planning anticipates the effects of termination in order to ensure a seamless transition from case management.
- Discharge planning also takes into consideration:
 - The reason that case management is being terminated.
 - Providing the member with reasonable notice that services are pending.
 - Identifying the member's progress meeting their case management goals.
 - Identifying the services and supports needed to further assist the member with optimizing functioning and remaining in his/her community.
- For members remaining in the program's geographic area of responsibility, the case manager:
 - Shares the results of discharge planning and all pertinent information with other providers delivering services to the member prior to discharge.
 - Provides the member with information about:
 - Recommended self-help and community resources; and

- How the member can resume case management.
- For members moving outside the program’s geographic area of responsibility, the case manager discusses the need for and availability of case management with the member. As needed, the case manager assists the member with accessing case management in the member’s new service area. The case manager maintains contact with the member through the transition.

References

State of Minnesota, Minnesota Department of Human Services. Mental Health Policies and Procedures, Adult Rehabilitative Mental Health Services, 2021.

State of Minnesota, Minnesota Department of Human Services. Provider Manual, Mental Health Services, 2021.

State of Minnesota, Minnesota Department of Human Services. EIDBI Benefit Policy Manual, Medical Necessity Criteria, 2021.

Chapter 245 Minnesota Statutes 2021.

Chapter 256 Minnesota Statutes 2021.

State of Minnesota, Minnesota Department of Human Services. Mental Health Policies and Procedures, 2021.

Minnesota Department of Human Services, Contract for Prepaid Medical Assistance and Minnesota Care with UnitedHealthcare (January 1, 2022).

Revision History

Date	Summary of Changes